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WILLIAM T FUJIOKA
Chief Executive Officer

July 16, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

LOS ANGELES COUNTY HOMELESS PREVENTION INITIATIVE STATUS REPORT

According to the Los Angeles Homeless Services Authority (LAHSA), Los Angeles County has the highest concentration of homelessness in the nation (50,000 people). Various social and economic factors, as well as gaps in available housing and social services, have contributed to the crisis.

On April 4, 2006, your Board approved the County Homeless Prevention Initiative (HPI) in response to this crisis. The HPI consisted of two categories of funding: (1) $15.4 million in funding for ongoing programs; and, (2) $80 million in one-time funding to develop innovative programs. Both funding categories are to focus on reducing or preventing homelessness. In approving the HPI, your Board directed the CEO to coordinate the preparation of quarterly status reports beginning in September 2006, providing your Board with implementation updates and analysis of results of the various HPI programs in reducing and preventing homelessness.

The Chief Executive Office continues to implement specific key HPI programs in partnership with County Departments of Children and Family Services, Health Services, Mental Health, Probation, Public Defender, Public Health, Public Social Services and the Sheriff, along with other agencies including the County's Community Development Commission, LAHSA, and various cities. Through March 2010, the HPI has been tremendously successful in implementing 32 programs and serving over 46,000 individuals and 20,000 families (some programs may serve the same participants).

The initiative focuses on reaching the following two goals through the six strategies shown below:

Goal 1 – Preventing Homelessness
- Housing assistance
- Discharge planning (transitional supportive services)

Goal 2 – Reducing Homelessness
- Community capacity building
- Regional planning
- Supportive services integration linked to housing
- Innovative program design

Three attachments are included with this memo:

1. Executive Summary of Fiscal Year (FY) 2009-10, Third Quarter;

2. HPI Status Report (Attachment A): The FY 2009-10 Third Quarter HPI status report includes information on program participants, services provided, and associated outcomes; and

3. Index of Programs (Attachment B): The table presents key performance indicators and budget information on each program. Following the table, each program's performance measures are included with a description of successes, challenges, an action plan, and a client success story.

This HPI report provides information about the progress of your Board's investment to decrease homelessness and inform future planning efforts. If you have any questions, please contact Kathy House, Acting Deputy Chief Executive Officer at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

WTF:BC:KH
VKD:ljp

Attachments (3)

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Community Development Commission
Health Services
Mental Health
Probation
Public Defender
Public Health
Public Social Services
Sheriff
City of Santa Monica
Los Angeles Homeless Services Authority
Public Counsel
Skid Row Housing Trust

Los Angeles County
HOMELESS PREVENTION INITIATIVE (HPI)

FY 2009-10, JANUARY – MARCH, THIRD QUARTER EXECUTIVE SUMMARY

Left and Right: Volunteers conduct interviews on the streets of Hollywood.

REACHING OUT TO THE HOMELESS IN HOLLYWOOD

The Hollywood Homeless Registry kicked off on April 26, 2010. For three nights during the pre-dawn hours, more than 80 volunteers interviewed the homeless in Hollywood. Kerry Morrison, Entertainment District Business Improvement District (BID) executive director led several street teams made up of volunteers from the private, public and nonprofit communities. Of the 323 homeless people identified, 257 participants agreed to be interviewed using the Vulnerability Index.

Based on research by Dr. Jim O'Connell, Common Ground developed the survey to identify those who are at higher risk for dying if they remain on the streets. Information collected from the survey has been used to develop strategies to reduce homelessness locally in downtown Los Angeles, Santa Monica, Venice, West Hollywood, Long Beach and Van Nuys.

After results from the Hollywood survey were presented at a community meeting held at the Los Angeles Film School, community members and local businesses pledged $62,000 for move-in costs for participants. Supervisor Zev Yaroslavsky committed County resources to provide mental health and health services for participants, and City Council President Eric Garcetti offered ten housing vouchers. Of the individuals who agreed to be surveyed, 44% experienced mental illness and substance abuse, and 14% were admitted to an emergency room (ER) or hospitalized over three times in the last year. By offering a safe and stable place to live in combination with supportive services, unnecessary ER and hospitalization costs can be avoided. Once the needs of the most vulnerable chronically homeless individuals are better understood, multi-agency planning will be critical to help participants achieve a better quality of life.

The HPI has served over 46,000 individuals and 20,000 families. For each strategy, specific outcomes and a combined total of estimated actual expenditures are listed. For both the Housing Assistance and Supportive Services Integration and Linkages to Housing strategies, cumulative results are shown.

GOAL 1: PREVENTING HOMELESSNESS

HOUSING ASSISTANCE
$10,899,999

Eviction Prevention
Moving Assistance
Rental Subsidy

Through housing assistance, individuals, youth, and families maintain permanent housing.

- **6,280 individuals and 13,955 families received housing assistance, which prevented homelessness.**

Note: A participant who received more than one type of housing assistance was counted once.

DISCHARGE PLANNING
$11,191,401

Access to Housing for Health
Homeless Release Projects
Just In-Reach Program
Recuperative Care

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

- **4,259 clients received public benefits.**
- **248 clients placed into permanent housing.**
- **85% decrease in inpatient days and 76% decrease in ER visits a year post enrollment.**

GOAL 2: REDUCING HOMELESSNESS

COMMUNITY CAPACITY BUILDING
$12,012,032

City and Community Program (CCP)
Revolving Loan Fund

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

- **4,163 individuals and 849 families received 11,714 linkages to supportive services and 1,436 housing placements.**

REGIONAL PLANNING
$4,465,683

Homeless Services
Long Beach Homeless Veterans

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

- **Gateway and San Gabriel Valley Council of Governments (COG) presented regional plans to include 1,253 units of permanent housing.**

SUPPORTIVE SERVICES INTEGRATION AND LINKAGES TO HOUSING
$16,551,215

Case Management
Housing Locators
Multi-disciplinary Team/Access Center

Provide clients with integrated supportive services and housing. Supportive services include case management, health care, mental health services, and substance abuse treatment.

- **15,289 individuals and 6,758 families placed into emergency, transitional, and permanent supportive housing.**
- **40,918 linkages to integrated supportive services enhanced participants' well-being.**
- **12,011 individuals and families achieved greater self-sufficiency through public benefits, income support, and connections to employment opportunities.**

INNOVATIVE PROGRAM DESIGN
$19,540,379

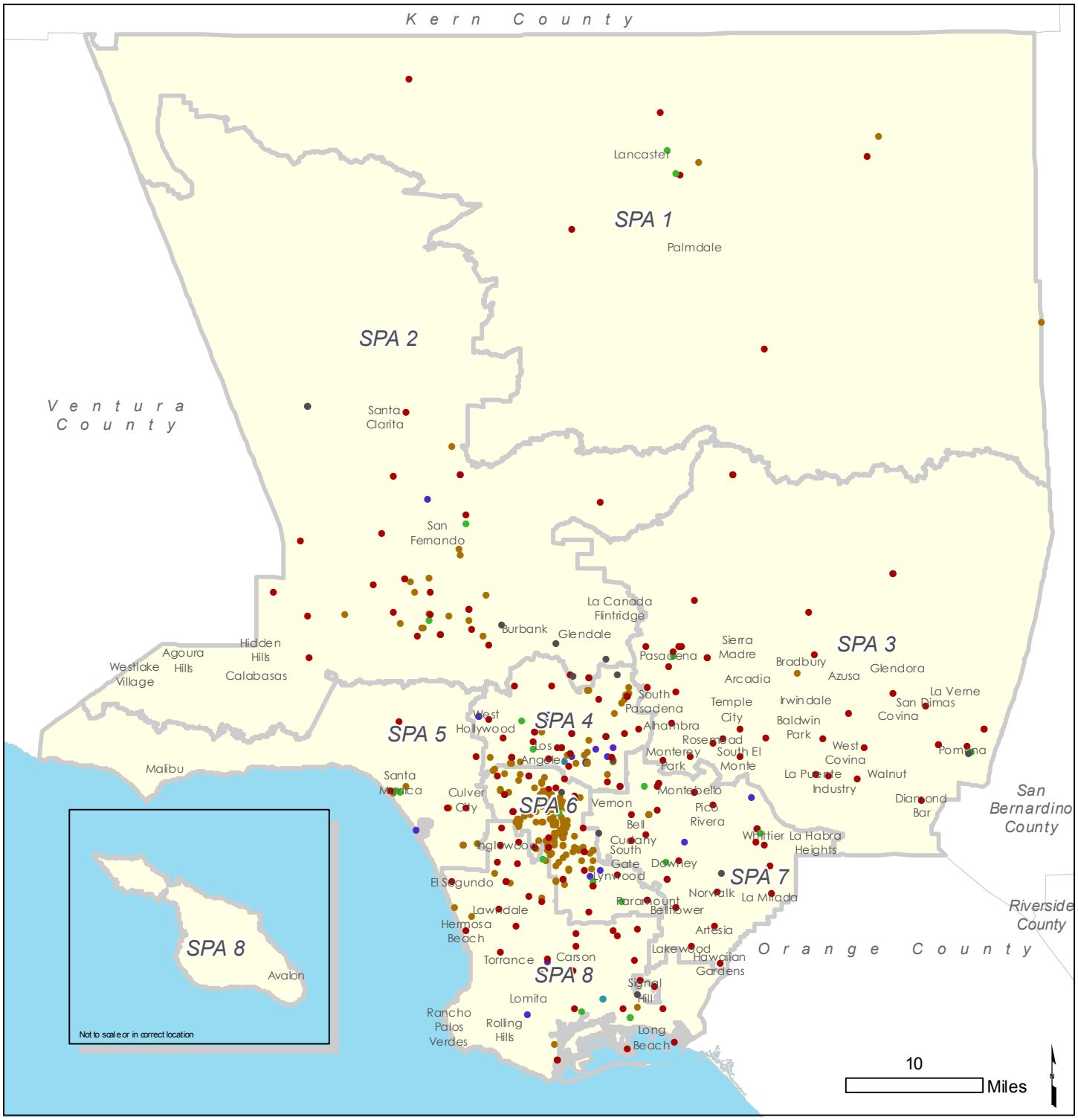
Project 50
Skid Row Families Demonstration Project
Homeless Court
Housing Resource Center
Santa Monica Service Registry

Provide access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

- **141 chronic homeless individuals placed into permanent supportive housing.**
- **241 Skid Row families placed into permanent rental housing (93% retained at 12 months).**
- **Citations and warrants dismissed for 1,922 individuals.**
- **Over 4.7 million housing searches conducted.**

County of Los Angeles Regional Homeless Prevention Initiative

Housing Placement and Service Locations by Service Planning Area (SPA)



Strategy

- 1 - Housing Assistance
- 2 - Transitional Supportive Services
- 3 - Community Capacity Building
- 4 - Regional Planning
- 5 - Supportive Services Integration and Linkages to Housing
- 6 - Innovative Program Design

Notes:

i) The following HPI programs are offered Countywide:
General Relief Housing Subsidy and Case Management Project
Los Angeles County Homeless Court
Los Angeles County Housing Resource Center
Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program
Project Homeless Connect

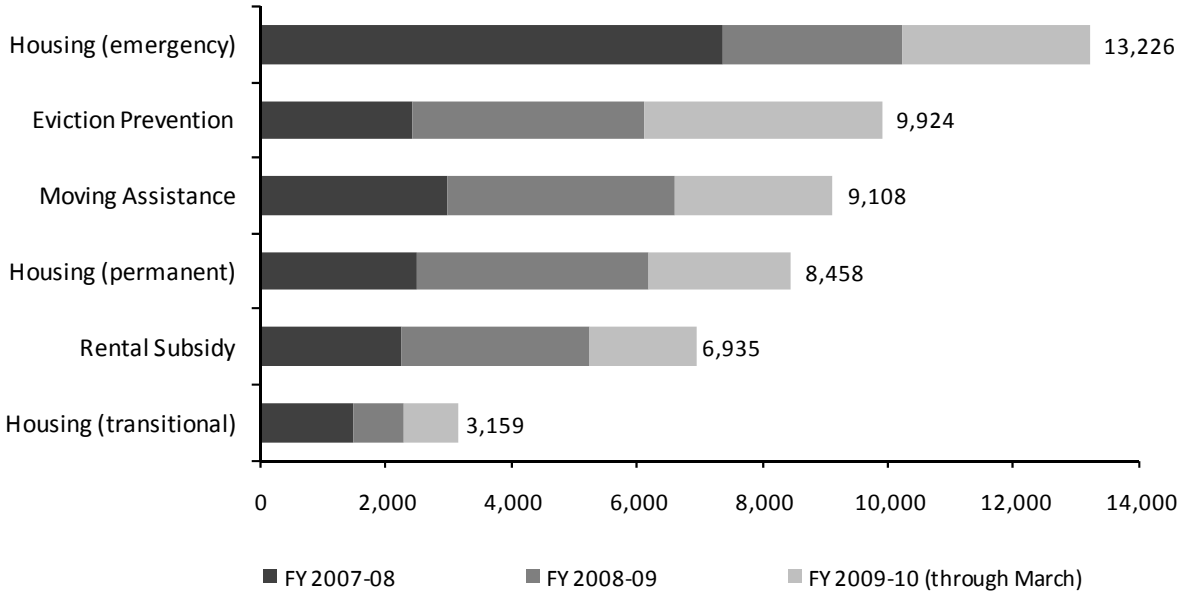
ii) Strategy 4 - Regional Planning includes San Gabriel Valley Council of Government Plan and Gateway Cities Homeless Strategy.

iii) Rental subsidies were provided to transition age youth who moved to cities in other counties, including: San Bernardino, Riverside, Kern, Orange, San Diego, Ventura, and Santa Barbara.

Map created by ISD/UR-GIS YM (562-940-2181) on 2009-05-14, HPI.mxd
Data from CEO/SIB, LACoeGIS Repository, and Thomas Bros Data.

It is the County's goal to work with community partners to further reduce and prevent homelessness. The chart below shows the number of HPI participants who received housing and financial assistance through March 2010.

HPI Participants Receiving Housing/Housing Assistance



Information about the County of Los Angeles Homeless Prevention Initiative

The Los Angeles County Board of Supervisors invested resources to address and prevent homelessness with the approval of the $100 million Homeless Prevention Initiative (HPI). The Chief Executive Office (CEO) continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), Community Development Commission (CDC), and various cities. To date, the HPI has been tremendously successful in implementing 32 programs and serving over 46,000 individuals and 20,000 families. The initiative focuses on reaching the following two goals through six strategies shown below:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Discharge planning (transitional supports)
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

For additional information, please contact Vani Dandillaya at vdandillaya@ceo.lacounty.gov.

COUNTY OF LOS ANGELES

Homeless Prevention Initiative (HPI)
FY 2009-10, Third Quarter Status Report

TABLE OF CONTENTS

Following the **Executive Summary** of this report are two attachments.

Attachment A: Overview of HPI Status

Attachment B: Index of HPI Programs by Population *(Table on page 1)*

HOMELESS PREVENTION INITIATIVE (HPI) STATUS REPORT
FY 2009-10, Third Quarter

I. INTRODUCTION

In accordance with your Board's direction on April 4, 2006, this report provides a status update on the implementation of 32 programs included in the Los Angeles County Homeless Prevention Initiative (HPI) during January-March of FY 2009-10. The Chief Executive Office (CEO) continues to implement specific key HPI programs in participation with the Community Development Commission (CDC), the Departments of Children and Family Services (DCFS), Health Services (DHS), Public Health (DPH), Mental Health (DMH), Public Social Services (DPSS), Probation, Public Defender, and the Sheriff. Representatives from these County agencies, departments, and several partner organizations meet frequently to ensure consistent communication and integration of services and facilitate successful implementation of HPI programs serving the County's homeless population.

HPI funding has allowed for greater access to housing and supportive services for the homeless and at-risk population. This HPI status update highlights results achieved through program strategies that have served over 46,000 individuals and 20,000 families.[1] This report features components of the HPI, associated outcomes, and opportunities to strengthen County homeless coordination.

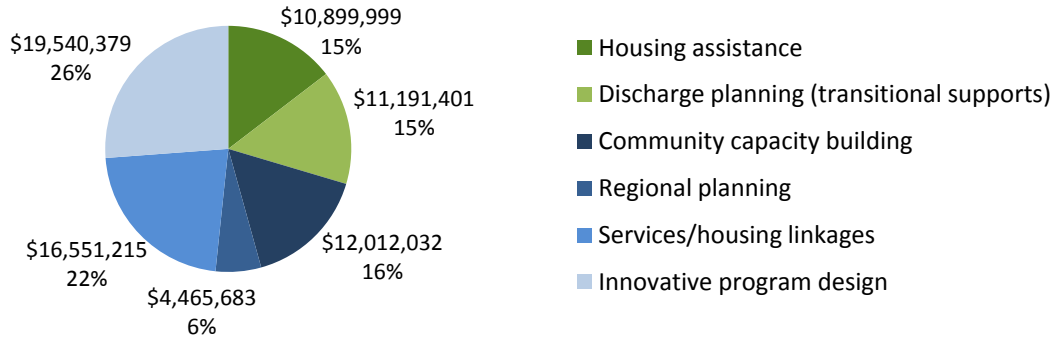
Goals and Strategies

As mentioned in the Executive Summary, the CEO continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), CDC, and various cities. The initiative focuses on meeting the following two goals through six strategies shown:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Discharge planning (transitional supports)
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

[1] Currently, a standardized data system is not in place to determine if any client is shared across programs, therefore, the total number of participants may include a duplicate count.

Chart 1: Estimated Actual Expenditures
Total: $74,660,709*



*Estimated actual expenditures are approximately $78.6 million. Additional expenditures include: 1) Board approved operational support at $1.9 million (FY 2006-07); and 2) operational support, administrative, and evaluation costs at approximately $2.0 million. *From upper right (clockwise) beginning with Housing Assistance.*

Estimated Actual Expenditures by Strategy

In this report, total expenditures include FYs 2006-07, 2007-08, 2008-09 actual expenditures and FY 2009-10 estimated actual expenditures. The total estimated actual expenditures for the HPI programs in this report are $74.6 million. Chart I shows that 30 percent of all expenditures have been spent on the initiative's first goal to prevent homelessness. Seventy percent of all expenditures have been spent on the HPI's second goal to reduce homelessness. In addition, Chart I shows the amount expended by each strategy. For the community capacity building strategy, capital projects for housing development have been delayed due to the economic conditions, therefore, the actual expenditures are significantly less than previously estimated for FYs 2008-09 and 2009-10. Through FY 2008-09, the greatest percentage (26 percent) of actual expenditures was spent on innovative programs, including *Housing First* models for chronically homeless participants.

The following sections of the HPI status report provide an overview of participants and the initiative's progress in preventing and reducing homelessness.

II. PARTICIPANTS

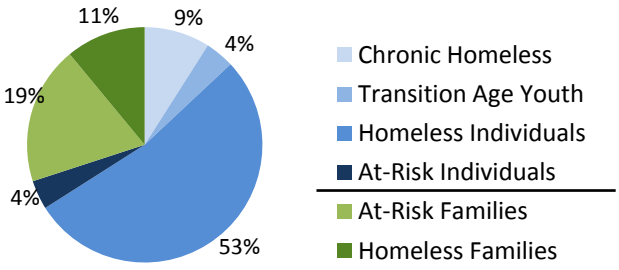
During the third quarter of FY 2009-10, 29 of 32 implemented HPI programs[2] directly served the County's homeless and nearly homeless. While several programs served more than one population, participants in 25 programs corresponded to one of five categories: homeless individuals (13 programs), chronic homeless individuals (four programs), transition age youth (two programs), homeless and at-risk families (six programs). Attachment B provides an overview of programs. To date, Table 1 shows HPI improved the lives of 46,249 individuals and 20,144 families.[3] During the third quarter, the number of families and individuals served increased by 12 percent.

Table 1: Number of Contacts by Participant Category
FY 2009-10 through March 31, 2010

	FY 2009-10*	FY 2008-09*	FY 2007-08	Cumulative	Third Qtr. Increase
Homeless Individuals	14,441	8,722	12,206	35,369	14%
Chronic Homeless Individuals	1,431	2,181	2,443	6,055	13%
Transition Age Youth	354	1,100	1,122	2,576	5%
At-Risk Individuals	1,266	983	-	2,249	11%
Total for Individuals	17,492	12,986	15,771	46,249	13%
Homeless Families	1,560	1,860	3,950	7,370	5%
At-Risk Homeless Families	5,205	5,082	2,487	12,774	13%
Total for Families	6,765	6,942	6,437	20,144	10%
TOTAL	**24,257**	**19,928**	**22,208**	**66,393**	**12%**

*FYs 2008-09 and 2009-10: To calculate an unduplicated count within each program, returning participants were not included.

Chart 2: Percent by Participant Category



From upper right (clockwise) beginning with Chronic Homeless.

Chart 2 illustrates that of HPI participants, 70 percent were individuals and 30 percent were families. According to LAHSA, 12 percent of the total homeless population lives in families,[4] and similarly homeless families made up 11 percent of all HPI participants. Of all HPI participants, 53 percent were homeless adults, four percent were at-risk adults, and four percent were transition age youth. Approximately one-fourth of the homeless in the County are chronically homeless,[5] while these individuals made up nine percent of all participants.

[2] While Housing Locator and Housing Specialists programs are included, these programs are funded by CalWORKs Single Allocation and DMH Mental Health Services Act (MHSA), respectively. City and Community Program includes 21 separate programs. Project Homeless Connect participants are not included in the total as many are connected to other programs.
[3] Note most programs provided an unduplicated participant number; however, four programs included a duplicated participant count during FY 2007-08. Housing Locators/Housing Specialists are included in total participant count.
[4] LAHSA 2009 Greater Los Angeles Homeless Count.
[5] Ibid.

Participant Characteristics

During the third quarter, all 29 programs provided demographic information for program participants. Demographic information included gender, age, and race/ethnicity of participants. To obtain data on HPI participants, demographic information from new participants served during this past quarter was included. Gender information from LAHSA contracted programs was added. Due to different categorization for race/ethnicity and age, these statistics for LAHSA contracted programs are shown separately in Attachment B.

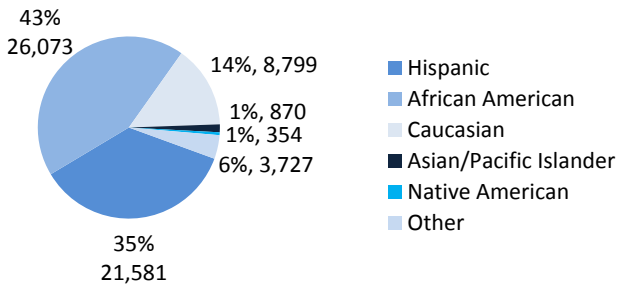
Gender

Approximately 67 percent of the homeless population in Los Angeles County consists of adult men.[6] Of the 66,036 participants whose gender was provided, 54 percent (35,876) were male and 46 percent (30,112) were female.

Race/Ethnicity

The total homeless population in Los Angeles County is 43 percent African American and 29 percent Hispanic/Latino. Chart 3 shows 43 percent of HPI participants were African American, 35 percent were Hispanic/Latino, and 14 percent Caucasian. The remaining eight percent of participants included Asian/Pacific Islander, Native American, and other racial/ethnic groups.

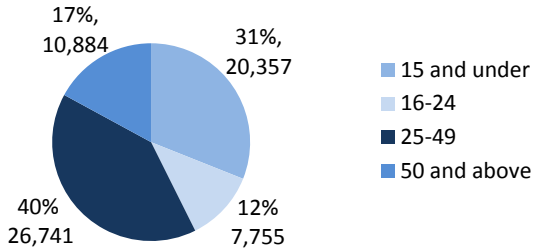
Chart 3: Race of HPI Participants (n=61,404)



Age

Of all HPI participants, a total of 40 percent was between 25-49 years of age. Chart 4 shows that of HPI participants whose age was provided, 31 percent were children 15 years of age or younger, 12 percent of participants were between the ages of 16-24, and 17 percent were 50 years of age and older.

Chart 4: Age of HPI Participants (n=65,737)



[6] LAHSA 2009 Greater Los Angeles Homeless Count.

III. GOALS, STRATEGIES, AND OUTCOMES

Goal I: Preventing Homelessness

Strategy 1 Housing Assistance $10,899,999

Through housing assistance, individuals, youth, and families maintain permanent housing.

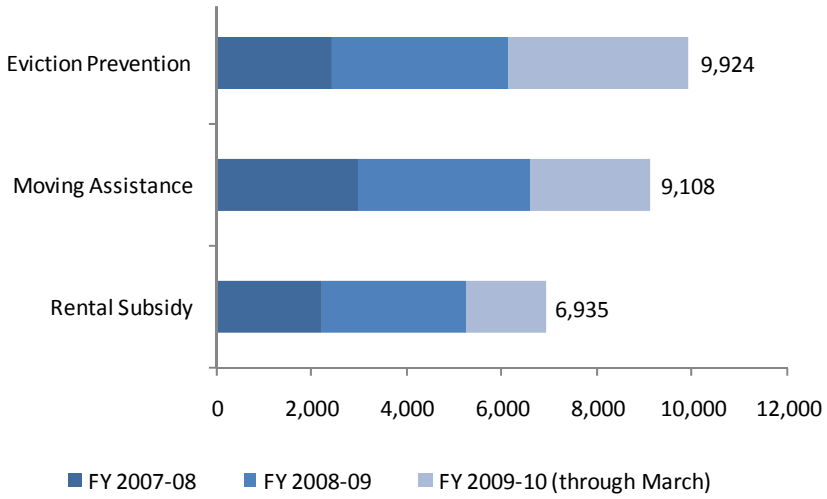
Eviction Prevention • Moving Assistance • Rental Subsidy

HPI programs provided housing assistance through moving assistance, eviction prevention, and rental subsidies; five programs focused on these services. ***Through March 2010, a total of 20,493 participants received housing assistance to secure permanent housing and prevent homelessness.*** A participant who received more than one type of housing assistance was counted once. Table 2 shows 69 percent of participants who obtained housing assistance were families, 25 percent were individuals, and six percent were transition age youth. Table 2 illustrates that a greater proportion of individuals and transition age youth received rental subsidies, whereas significantly more families obtained eviction prevention. Chart 5 shows the number of participants who received each type of housing assistance through March 2010.

Table 2: Through March 2010		Housing Assistance	Moving Assistance	Rental Subsidy	Eviction Prevention
Individuals	5,121	25%	3,427	5,393	128
Transition Age Youth	1,159	6%	603	1,040	2
Families	13,955	69%	4,997	390	9,729
Total participants	20,235	100%	9,027	6,823	9,859
Expenditures		**$10,899,999**	**$6,193,951**	**$902,274**	**$3,803,774**

The following participants were not included in Table 2: 81 participants who received moving assistance, 65 who received eviction prevention, and 112 who received rental subsidies.

Chart 5: Housing Assistance Provided to HPI Participants



Strategy 2 Discharge Planning (Transitional Supports) $11,191,401

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

Access to Housing for Health (AHH) • Recuperative Care • Homeless Release Projects (DPSS-DHS and DPSS-Sheriff) • Just In-Reach Program (JIR)

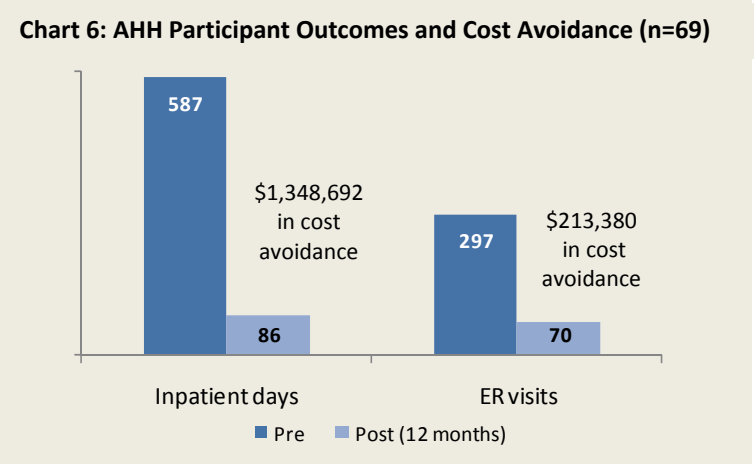
Discharge Planning for Hospital Patients

Access to Housing for Health (AHH), Recuperative Care, and DPSS-DHS Homeless Release programs provided discharge planning for hospital patients at-risk of becoming homeless. A discharge plan connected patients to services that helped them attain stable housing and a better quality of life. Both the AHH and Recuperative Care programs have shown improvements in health outcomes, such as reductions in Emergency Room (ER) visits and inpatient hospitalizations.

Outcomes

- ***Improved Health***: Since March 2007, 69 AHH clients completed 12 months with a 76% decrease in ER visits and an 85% reduction in inpatient days.
- ***Cost Avoidance:*** After 12 months, a reduction in the number of AHH patients' ER visits and inpatient days resulted in the cost avoidance of over $1.5 million (Chart 6).
- ***Linkages to Public Benefits***: These programs made 641 connections to public benefits for individuals, including: Supplemental Security/Disability Income (SSI/SSDI), Medi-Cal, and General Relief (GR).
- ***Housing Stability***: AHH placed 94 individuals into permanent housing, and 97 percent (70 individuals to date) have maintained permanent housing for six months or more.

Chart 6: AHH Participant Outcomes and Cost Avoidance (n=69)



Discharge Planning for Individuals Released from Jails

Just In-Reach (JIR) and DPSS-Sheriff Homeless Release projects connected individuals to services and benefits prior to release from jail to help support steps towards building a better future, including stable housing and employment.

Outcomes

- ***Linkages to Public Benefits***: The JIR and DPSS-Sheriff Homeless Release projects served 6,432 individuals and made 3,618 connections to such public benefits as: GR, Food Stamps, SSI/SSDI, and Veteran's benefits.
- ***Housing Placement***: Housing locators assisted 422 individuals with housing placement. Through the JIR program, 199 clients identified as homeless or chronically homeless have been released to housing, transitional living or a residential program.
- ***Transition to Communities:*** By offering case management to all JIR clients, 521 linkages have been made to job training/placement or education. The recidivism rate of JIR participants has been 34% over the past 21 months, which is considerably less than that of the general County Jail system population (53%).

Goal 2: Reducing Homelessness

Strategy ❸ Community Capacity Building $12,012,032

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

City and Community Program (CCP) • Revolving Loan Fund

City and Community Program (CCP)

- Fifteen programs served 4,176 individuals and 859 families. The programs made ***11,714 linkages to supportive services and 1,436 housing placements***. Three permanent supportive housing programs showed an average housing retention rate of 88% at six months.
- Nine capital projects were funded, and the CDC is in constant contact with all developers. The CDC has set up internal tracking systems to monitor progress. It is customary for grants to be executed near the start of construction. Loan agreements are being finalized for three projects. Many projects have been delayed by the State budget freeze. As of June 2009, the Bell Shelter project was completed to provide an additional 30 beds of transitional housing with supportive services for individuals. During the third quarter, the CDC executed the contract with Cloudbreak Compton, LLC, for the Compton Vets Services Center. Construction is projected to be completed by January 2011.

Revolving Loan Fund (RLF)

The current lending environment has been a challenge for many affordable housing developers. Moreover, developers need to be able to access funds to pay off Los Angeles County Housing Innovation Fund (LACHIF) loans. During this reporting period, the LACHIF closed one loan for $3.7 million. Additionally, Citibank provided $20 million in Class A capital. LACHIF lenders and CDC staff continue to market the fund. Previously, the Hudson Oaks loan was made by Century Housing to Abode Communities. Hudson Oaks is located in the City of Pasadena and will provide 45 units of affordable senior housing.

Strategy ❹ Regional Planning $3,250,000

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

Gateway Cities Council of Government (COG) • San Gabriel Valley COG • Long Beach Homeless Veterans

- The San Gabriel Valley Council's of Government (COG) and the Gateway Cities COG are in the process of beginning phase II of their respective initiatives. Phase II will consist of overseeing the implementation of each plan. The efforts will serve to create affordable permanent housing, interim housing, homeless services, and capacity building. The County's Chief Executive Office is creating funding agreements with the COGs and/or their contracted partner to support these efforts.
- Over the next five years, San Gabriel Valley COG's Regional Homeless Service Strategy includes an objective to create 588 units of permanent supportive housing, and PATH Partners' Gateway Cities Homeless Strategy plans to create 665 permanent supportive housing units (Attachment B, p. 67).
- Long Beach Homeless Veterans provide case management, child support reduction, mental health

care, and housing. The County CEO's Research and Evaluation Services' analysis suggested that the program offset $1.4 million in County services after one year.[7] During this quarter, Single Parents United N Kids (SPUNK) closed ten child support cases for a total arrears savings of $341,508. The City of Long Beach continued outreach efforts to homeless veterans, including ongoing referrals to the Long Beach Veterans Affairs (VA) Healthcare System HUD-Veteran Affairs Supportive Housing (VASH) Voucher program.

Strategy 5 Supportive Services Integration and Linkages to Housing $16,551,215

Clients receive integrated supportive services and housing.

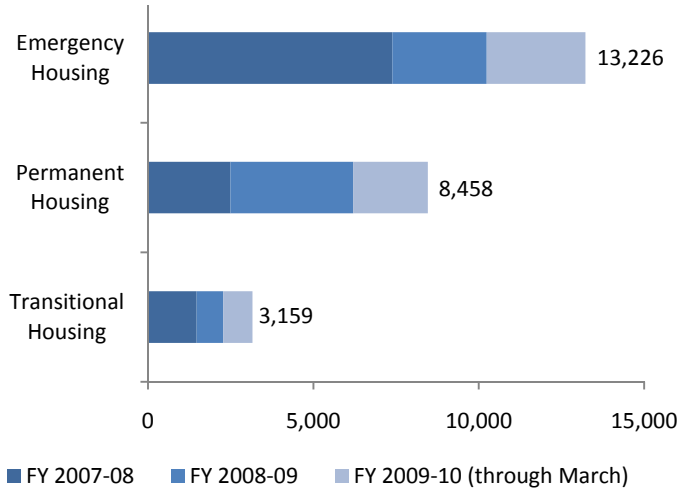
Case Management • Housing Locators • Multi-disciplinary Team/Access Center • Project Homeless Connect • Benefits Entitlement Services Team for the Homeless (B.E.S.T.)

Linkages to Housing – Chart 7 shows that a total of 8,458 households received permanent housing. Of the total categorized by population, Table 3 shows 61 percent were families, 11 percent transition age youth, and 28 percent individuals. In contrast, 84 percent of individuals received emergency/transitional housing placement. This quarter, 17 programs placed participants into temporary housing, and participants spent an average of 75 days in temporary housing prior to permanent or transitional housing.

Table 3: Housing Placement through March 2010	**Emergency/ Transitional**		**Permanent Housing**	
Individuals	11,868	84%	2,238	28%
Transition Age Youth	338	2%	845	11%
Families	1,966	14%	4,792	61%
Total	**14,172**	**100%**	**7,875**	**100%**

Services not categorized by population above: 583 who were moved into permanent housing; 1,366 who were moved into transitional housing; and 847 who were placed into emergency housing.

Chart 7: HPI Participants Moved into Housing



[7] Stevens M, et al. *Cost Avoidance Yielded Through Participation In The Long Beach Homeless Veterans Initiative*. County of Los Angeles, Chief Executive Office. Service Integration Branch, Research and Evaluation Services. March 2010.

Supportive Services Integration – Participants received supportive services in three categories: 1) employment/education, 2) benefits advocacy and enrollment assistance, and 3) health and human services.

Employment/Education Services and Support

Through March 2010, 22 HPI programs reported a total of 2,874 participants received job and/or education related supports (Table 4). Sixty-one percent of these participants received job training, referrals, or related resources. Participants in these programs included transition age youth, chronic homeless individuals and families on Skid Row, and participants with co-occurring disorders. As programs continue to make linkages to job and education related services and build infrastructure for data collection, these numbers have increased. By supporting the employable homeless to overcome barriers in obtaining and maintaining employment, more individuals have attained greater self-sufficiency.

Table 4: Jobs/Education	FY 2009-10	Cumulative*	Percent
Job training/referrals/resources	859	1,748	61%
Education (course, class, books)	227	614	21%
Job placement (employment)	214	512	18%
Total number of services provided:	**1,300**	**2,874**	**100%**

*Cumulative includes: FYs 2008-09 and 2009-10 through March 31, 2010.

Benefits Advocacy and Enrollment Assistance

For participants who entered programs in need of specific public benefits, 26 HPI programs reported enrolling homeless individuals and families. Table 5 shows that through March 2010, 5,446 homeless individuals were enrolled into General Relief, which consisted of 60 percent of all benefit enrollments. Eleven percent of participants were enrolled into Supplemental Security/Disability Income (SSI/SSDI), and 11 percent received Shelter Plus Care or Section 8 to secure permanent housing. Compared to enrollments from the previous quarter, veteran's benefits increased the most with 59 percent more enrollments, followed by Medi-Cal (17 percent), and SSI/SSDI (13 percent).

Table 5: Benefits	FY 2009-10	Cumulative*	Percent
General Relief (and Food Stamps)	1,138	4,655	51%
SSI/SSDI	508	1,045	11%
General Relief only	192	791	9%
Shelter Plus Care	278	640	7%
Medi-Cal or Medicare	303	596	7%
Food Stamps only	243	432	5%
Section 8	148	412	4%
CalWORKs	204	364	4%
Veterans	161	202	2%
Total number of benefits provided:	**3,175**	**9,137**	**100%**

*Cumulative includes: FYs 2008-09 and 2009-10 through March 31, 2010.

Supportive Health and Human Services

Through the third quarter of FY 2009-10, 29 programs made 40,918 linkages between participants and supportive health and human services. These programs served homeless and chronic homeless individuals, homeless families, and transition age youth. Table 6 shows 23 percent (9,347) of these HPI participants received health care, which was the most frequently reported supportive service. Followed by health care, 22 percent of linkages were for case management (9,130), and 16 percent (6,664) were for mental health care. Another nine percent of these linkages connected participants to transportation services, including bus tokens and public transportation.

With 69 percent of the homeless population having a mental illness, substance abuse problem, or AIDS/HIV-related illness,[8] linking these individuals and families with health care, mental health care, and substance abuse services is critical. Additionally, with the Recovery Act's Homelessness Prevention and Rapid Re-Housing Program (HPRP) funds, the County has expanded services to assist families and individuals with credit repair, legal assistance, and money management. In a 2009 HPI survey, providers also indicated interest in improving access to child care, law enforcement, and employment support.

Twenty-eight programs reported providing case management services, and 16 programs selected the most intense level of case management. The HPI Report Form asked about the level of case management provided, with level one assessing the client and level three assisting with supported referrals and counseling.[9] Hours provided to each participant per month ranged from 30 minutes to 255 hours (average of 29 hours) with an average caseload of 32 cases per case manager.

Table 6: Supportive Services	FYs 2008-09 and 2009-10 (through March)	Percent	FY 2007-08*
Health care	9,347	23%	183
Case management	9,130	22%	2,257
Mental health care	6,664	16%	615
Transportation	3,854	9%	182
Life skills	3,270	8%	676
Alternative court	1,934	5%	286
Resident rights/responsibilities	1,537	4%	-
Substance abuse treatment	1,104	3%	130
Social/community activity	1,216	3%	51
Food vouchers/food	1,344	3%	414
Recuperative care	637	1%	45
Other**	382	1%	5
Clothing/hygiene	287	1%	80
Legal services	212	1%	15
Total number of services provided to participants:	**40,918**	**100%**	**4,939**

* For FY 2007-08, this report includes LAHSA contracted programs that provided referrals to mental health care (including domestic violence counseling) and substance abuse treatment.

**Other services include: auto insurance, driver's license release, identification card, and credit repair.

[8] LAHSA 2009 Greater Los Angeles Homeless Count.

[9] Post PA. *Developing Outcome Measures to Evaluate Health Care for the Homeless Services*. National Health Care for the Homeless Council. May 2005.

Strategy 6 Innovative Program Design $19,540,379

Provides access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

Project 50 • Santa Monica Service Registry • Skid Row Families Demonstration Project • Homeless Courts • Housing Resource Center • Long Beach Housing Now

INNOVATIVE PROGRAM OUTCOMES

Housing First Models

- **Housing stability**: On average, *Housing First* models showed a successful 90 percent housing retention rate for individuals and families in permanent housing for six or more months. Housing First programs include: Project 50, Skid Row Families Demonstration Project, and the Santa Monica Service Registry.
- **Increased income**: After one year, Project 50 participants showed a 56 percent increase in benefits since enrollment.
- **Improvement in overall health and well-being**: At the end of one year, Project 50 participants spent significantly fewer days in ERs, hospitals, and jails with considerable cost savings for the County.

Homeless Courts

- **Pathways to self-sufficiency**: Ninety-three percent of Homeless Court participants had their warrants or citations dismissed, and they have been able to move forward by securing employment, reconnecting with their families, and planning for their future.

Los Angeles County Housing Resource Center (LACHRC)

- **Information sharing**: Over 4.7 million searches for housing listings have been conducted online. Nearly 9,000 landlords are registered on the website.

The HPI Report Form requested for programs to report on three outcome areas for participants receiving services for 6, 12 and 18 months. The three outcome areas were: 1) housing stability, 2) education and employment status, and 3) health and well-being. Seventeen programs that served chronic homeless individuals, transition age youth, and homeless individuals and families reported on these longer-term outcome areas.

Point in time outcomes for this past quarter at 6, 12, or 18 months post enrollment:

- **Housing stability**: A total of 1,790 participants continued to live in permanent housing and 1,371 continued to receive rental subsidies.
- **Employment/education**: A total of 109 participants obtained employment, 364 maintained employment, and 262 enrolled in an educational program.
- **Health and well-being**: The following number of participants continued to receive these services for six months or more: 1,977-case management; 1,271-health care; 829-mental health services; and 229-substance abuse treatment.

A brief description of each innovative program:

- **Project 50** – The project is a successful collaboration that includes over 24 government and non-profit agencies. Based on Common Ground's *Street to Home* strategy, Project 50 integrates housing and supportive services for vulnerable, chronic homeless individuals living near downtown Los Angeles on Skid Row. A year after its launch, the pilot successfully moved 50 vulnerable, chronic homeless individuals off of Skid Row with an impressive housing retention rate of 86 percent. Moreover, significant decreases in hospitalizations and emergency room visits indicate improved health and behavioral health outcomes. In addition to improving the quality of life for these 50 individuals, estimates show considerable cost savings as a result of fewer days spent in ERs, hospitals, and jails.

- **Skid Row Families Demonstration Project** – A total of 241 families have been placed into permanent housing. Of these families, 93 percent have successfully maintained permanent housing for six or more months (221 have maintained their permanent housing for 12 months or more, and three families have maintained permanent housing for seven to 12 months). For the first six months in permanent housing, families are offered home-based case management. Consistent contact has enabled the Housing First Case Managers to develop positive relationships based on trust. Case management has included linking families to various supportive services, including: community resources, mental health referrals, school referrals, job training referrals, money management, and financial planning. After six months of home-based case management to help families stabilize, the majority of families received follow-up phone calls to ensure they are doing well and are not in crisis.

- **Homeless Courts** – A total of 1,922 individuals have had their warrants or citations dismissed as a result of successful completion of mental health and/or substance abuse treatment requirements of the Los Angeles County Homeless Court and Santa Monica Homeless Community Court. In addition, 12 individuals have graduated from the Co-Occurring Disorders Court to have charges dismissed. As a result of having outstanding warrants, citations, or charges resolved, these individuals have been able to move forward by securing employment, reconnecting with their families, and planning for their future. For example, one participant obtained his GED, became a certified cook and hopes of owning his own restaurant. Another participant said that the program has changed his life by helping him achieve sobriety for over 17 months and reunite with his family.

- **Los Angeles County Housing Resource Center (LACHRC)** – The online database provides information on housing listings for public users, housing locators, and caseworkers. Over 4.7 million searches have been conducted by users to receive listings. The LACHRC is an excellent example of using technology to make information more accessible, and clients are very grateful for this service. In October 2009, the LACHRC added a pre-screening feature to determine HPRP program eligibility and further improve system navigation for clients.

IV. PROGRAM NARRATIVE (included in Attachment B)

Each quarter, programs provide information on successes, challenges, and action plans. A review has identified four common themes in implementing strategies to reduce homelessness: collaborative partnerships, innovative processes, outreach strategies, and leveraged funds.

Client Success Stories

Gaining independence after completing PATH Achieve Glendale program
A single mother came to PATH Achieve Glendale newly clean and sober, but without a job and without her children. After just five weeks in the Emergency Housing Program, the client had obtained a new job serving meals at a retirement home for $7.25 an hour. Soon after, she moved to the Transitional Housing Program, which provides low rent, case management, support and encouragement. She successfully completed the program in less than two years. Today her children live with her in a lovely two-bedroom apartment that she is able to pay for without assistance because she now earns $18 an hour as an executive secretary.

Receiving support at the National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY Long Beach
A 24-year-old client was identified as one of the most vulnerable homeless youth in the downtown Long Beach area during the recent *Homeless Connections Initiative* in Long Beach (modeled after Los Angeles' *Project 50*). The client comes from a family history that includes mental health issues, substance abuse, homelessness, and poverty. When staff met him during homeless outreach, he was being allowed to stay at a local church overnight because he had no place to live, and his mother was in a similar situation. Although Client B has mental health issues and a history of trauma, staff gained his trust and started talking to him about what he wanted in life, offering him meals, and getting to know him. Within a few months, staff helped him locate an apartment and assisted him with the funds. The program paid his rent for the next six months with additional funding from a U.S. Department of Housing and Urban Development (HUD) grant. The program helped him explore local colleges and job opportunities, and his chances at self-sufficiency and happiness are looking very good. This would not have been possible without the support of this grant.

Finding strength to overcome addiction at the Southern California Alcohol and Drug Programs (SCADP), Inc. - Homeless Co-Occurring Disorders Program
In the past six months, a 53-year-old client received a Section 8 voucher and her SSDI benefits. She is now established in her own permanent place. Shortly after moving in, she had a heart attack. She was hospitalized for some time. Unlike before, she contacted her family and support network. When she was released, she moved back home and began attending heart health classes at the hospital. She commented that had this happened before she went into treatment, she probably would have left the hospital and not told anyone and started drugs again. She is proud to endure this exceedingly stressful event in her life without resorting to drugs, and she could not remember ever being as determined.

V. STRENGTHENING COUNTY HOMELESS COORDINATION

On November 17, 2009, the County Board of Supervisors passed a motion instructing the CEO, with assistance from DCFS, DHS, DMH, DPSS, the CDC, and LAHSA, to develop recommendations on how to strengthen the CEO's ability to oversee, coordinate and integrate Countywide homeless service delivery so that homeless individuals and families can more successfully find safe and permanent housing. In response, a CEO report to the Board on January 4, 2010 made three main recommendations to strengthen the County's homeless strategy. The CEO provided another update to the Board in May 2010 which informed of progress made in each of the three recommended areas –

Leverage funds to maximize resources

The City of Los Angeles (City) and CDC have demonstrated their willingness to partner with the County to leverage their housing resources with County services. The Special Needs Housing Alliance (SNHA) workgroup team will work to strategically align and maximize the CDC's, the City's and other cities' housing dollars with County resources for services. The City and CDC recognize the value of working with the County to determine which clients should be targeted for housing during the design and development phase of housing projects and well in advance of project completion. This presents an opportunity to work together to get the most cost intensive clients off the streets and out of shelters and into permanent housing with supportive services, which results in significant cost avoidance. One example involves the County's partnership with the Skid Row Housing Trust (SRHT) on the Charles Cobb Apartments (Cobb Apartments). In exchange for the County's $2.5 million investment of Mental Health Services Act (MHSA) Housing Program funds, SRHT set aside 25 of the 76 units for MHSA eligible clients identified as some of the most vulnerable homeless in Skid Row. With the assistance of the Housing Authority of the City of Los Angeles, the County received permission from HUD to move the existing Project 50 clients to the Cobb Apartments. On June 17, 2010, the Skid Row Housing Trust opened the $13.1 million Charles Cobb Apartments with 76 units for permanent supportive housing.

Coordinate a regional approach among partners

The County recognizes the importance of the Homeless Coordinator position to strengthen the coordination and integration of services targeting the homeless population. As a result of recruiting for this position, the County has offered the Homeless Coordinator position to a candidate who will begin in early FY 2010-11. In an attempt to begin the coordination of a regional approach, the workgroup is continuing to work with the City and the CDC to develop a coordinated plan to leverage its housing resources with County services. If the team successfully develops a blueprint of a Memorandum of Understanding to align housing resources for service resources with the City, this will be used as a model to begin the work with other cities that are interested in working with the County and want to bring their housing resources to the table.

Address cost avoidance

One of the several cost avoidance reports and studies related to serving homeless persons mentioned the Service Integration Branch (SIB) - Research and Evaluation Services Adult Linkages Project and LAHSA's commissioned report, Where We Sleep: Costs When Homeless and Housed in Los Angeles conducted by the Economic Roundtable. The SIB cost avoidance analysis is scheduled to be completed by June 2011. The research to date makes clear that housing the homeless results in cost savings.

Significant progress has been made to develop collaborative working partnerships with multiple public and private agencies and philanthropic organizations. It is the County's intent to work with the SNHA to put together an action plan with a timeline that would continue to align resources, while at the same time not increase net County cost (NCC) and maximize resources to serve homeless individuals and families. The CEO will continue to develop partnerships with cities and communities throughout the County to create regional solutions to address homelessness. Monthly Board briefings and homeless coordination meetings include staff from Board offices, County departments, LAHSA, CDC, and several cities to provide updates on the HPI budget and programs. The forum is an opportunity to discuss various homeless issues. Each of these efforts and the Board's continued investment will ensure that the initiative to reduce homelessness in Los Angeles in successful.

VI. Acknowledgements

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Table of Homeless Prevention Initiative (HPI) Programs

Attachment B

	Program	Indicator (to date)	Target	Funding	Budget
	Families (I)				
3 ❶	1. Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	9,572 families received eviction prevention to prevent homelessness	2,079	One-Time	$500,000
❶	2. Moving Assistance for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families	4,692 families received moving assistance and permanent housing	1,305 450	One-Time	$1,300,000
❶	3. Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	211 families received rental subsidies to prevent homelessness	1,475	One-Time	$4,500,000
5 ❺	4. Housing Locators	573 families placed into permanent housing	n/a	*DPSS*	$1,930,000
6 ❻	5. Skid Row Families Demonstration Project	241 families placed into permanent housing	300	Board Approved	$9,212,000
8 ❺	6. Multi-disciplinary Team Serving Families	240 families received case management services	n/a	Ongoing	$494,000
	Transition Age Youth (II)				
10 ❶	7. Moving Assistance/Rental Subsidies for TAY – DCFS	538 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
10 ❶	8. Moving Assistance/Rental Subsidies for TAY – Probation	366 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
	Individuals (III)				
12 ❷	9. Access to Housing for Health (AHH)	94 clients placed into permanent housing 85% decrease in inpatient days; 76% in ER visits	115 cap	Board Approved	$3,000,000
14 ❺	10. Benefits Entitlement Services Team for the Homeless (B.E.S.T.)	22 individuals received SSI approval	Individuals	One-Time	$2,000,000
15 ❺	11. Center for Community Health Downtown Los Angeles	4,661 individuals received health/mental health care	n/a	Ongoing	*$186,000
16 ❺	12. Co-Occurring Disorders Court	54 individuals placed into transitional housing	n/a	Ongoing	$200,000
19 ❷	13. DPSS General Relief Housing Subsidy & Case Management Project	3,198 homeless GR participants received housing subsidies for housing placement	900 time	Ongoing	$4,052,000
20 ❷	14. DPSS-DHS Homeless Release Project	473 potentially homeless participants received benefits	n/a	Ongoing	$588,000
20 ❷	15. DPSS-Sheriff's Homeless Release Project	3,373 potentially homeless individuals received benefits	n/a	Ongoing	$1,171,000
22 ❷	16. Homeless Recuperative Care Beds (DHS)	486 individuals were served through this program 70% decrease in hospitalizations; 28% in ER visits	490/2yr	One-Time	$2,489,000
24 ❺	17. Housing Specialists (most clients are individuals)	777 placed into permanent housing	n/a	*DMH MHSA*	$923,000
25 ❷	18. Just In-Reach Program	245 individuals received public benefits	Individuals 400/2 yr	One-Time	$1,500,000
27 ❻	19. Long Beach Housing Now – PATH Ventures	New project to house chronically homeless	Board Approved		$300,069
28 ❹	20. Long Beach Services for Homeless Veterans (mostly individuals)	270 veterans received case management services	n/a	Ongoing	$500,000
30 ❻	21. Los Angeles County Homeless Court Program	1,804 individuals with citations or warrants dismissed	n/a	Ongoing	$379,000
32 ❶	22. Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program	371 single adults received moving assistance to prevent homelessness	until 2,000	One-Time	$1,100,000
33 ❻	23. Project 50	67 chronically homeless placed into permanent housing	50	One-Time	$3,600,000
35 ❻	24. Santa Monica Homeless Community Court	118 individuals with citations or warrants dismissed	90	Board Approved	$571,000

Table of Homeless Prevention Initiative (HPI) Programs

Attachment B

	Program	Indicator (to date)	Target	Funding	Budget
37 ❻	25. Santa Monica Service Registry (programs a and b)	74 chronic homeless individuals have participated	n/a	3rd District	$1,178,000
	Multiple Populations (IV)				
41 ❻	26. Los Angeles County Housing Resource Center	Over 4.7 million housing searches conducted	n/a	Ongoing	$202,000
42 ❺	27. LAHSA contracted programs	9,264 placements into housing	n/a	One-Time	$1,735,000
42 ❺	28. PATH Achieve Glendale (families and individuals)	298 placements into permanent housing	n/a	One-time	$200,000
44 ❸	29. Pre-Development Revolving Loan	$3.7 mil. loan closed for 45 affordable units for seniors	n/a	One-Time	$20,000,000
45 ❺	30. Project Homeless Connect	2,212 households connected to services (since 12/09)	n/a	One-Time	$45,000
46 ❸	31. **City and Community Program - CCP (V)**	$11.6 m capital, $20.6 m City Community Programs	Multiple	One-Time	$32,000,000
71 ❹	32a. **San Gabriel Valley Council of Governments - COGs (VI)**	Final report completed in March 2009	n/a	Ongoing	$200,000
71 ❹	32b. Gateway Cities Homeless Strategy	Final report completed in March 2009	n/a	Ongoing	$135,000
	HPI Funding Total (excludes Board approved operational support (FY 2006-07), administrative and evaluation costs) *Ongoing costs expected to be $76,000				**$99,690,069**

46 ❸	*City and Community Program (CCP) Funds*	Service ($)	Capital ($)
	a. Catalyst Foundation for AIDS Awareness and Care – Expansional Supportive Services Antelope Valley	1,800,000	
	b. City of Pomona – Community Engagement & Regional Capacity Building	1,079,276	
	c. City of Pomona – Integrated Housing & Outreach Program	913,975	
	d. A Community of Friends – Permanent Supportive Housing Program	$1,800,000	
	e. Homes for Life Foundation – HFL Vanowen	369,155	
	f. Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley	900,000	
	g. Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Long Beach	1,340,047	
	h. Ocean Park Community Center (OPCC) – HEARTH	1,200,000	
	i. Skid Row Housing Trust – Skid Row Collaborative 2 (SRC2)	1,800,000	
	j. So. California Alcohol & Drug Programs, Inc. (SCADP) – Homeless Co-Occurring Disorders Program	1,679,472	
	k. Special Service for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program	1,800,000	
	l. Union Rescue Mission – Hope Gardens Family Center	756,580 1,096,930	646,489
	m. Volunteers of America of Los Angeles – Strengthening Families	1,000,000	
	n. Women's and Children's Crisis Shelter	300,000	
	Beyond Shelter Housing Dev. Corp. – Mason Court Apartments		$680,872
	Century Villages at Cabrillo, Inc. – Family Shelter EHAP I & II		1,900,000
	City of Pasadena – Nehemiah Court Apartments	102,685	858,587
	CLARE Foundation, Inc. – 844 Pico Blvd., Women's Recovery Center	1,050,000	1,000,000
	Cloudbreak Compton LLC – Compton Vets Services Center	322,493	1,381,086
	So. California Housing Development Corp. of L.A. – 105th and Normandie	200,000	600,000
	The Salvation Army – Bell Shelter Step Up Program		500,000
	Total for Service and Capital	$19,510,613	$7,567,034
	Grand Total for CCP*	**$27,077,647**	

**Actual total of $32 million includes administrative costs.*

For this report, unless specified: Fiscal Year (FY) refers to the first, second, and third quarters of FY 2009-10 (January 1, 2010 – March 31, 2010). Cumulative refers to the number of clients served to date. Note: complete demographic information may not have been provided.

I. PROGRAMS FOR FAMILIES

1, 2, 3) DPSS Programs: Moving Assistance, Eviction Prevention, and Rental Subsidy

Goal: Assist families to move into and/or secure permanent housing.

Budget: (One-Time Funding)

1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families (EAPE)	$500,000
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	$1,300,000
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	$4,500,000

Table A.1: DPSS Services for Families by Program
FY 2009-10, through March 31, 2010

Program (unduplicated count)	FY	Cumulative
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	3,556 received eviction prevention	9,572 received eviction prevention
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	1,338 received moving assistance and permanent housing	4,692 received moving assistance and permanent housing
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	Program ended in FY 2008-09.	211 received rental subsidies for permanent housing

Table A.2: DPSS Measures by Program
FY 2009-10, through March 31, 2010

Program (unduplicated count)	Number of applications received		Percent of applications approved		Average amount of grant	
	FY	To date	FY	To date	FY	FY 08-09
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	4,814	13,817	66%	69%	$676	$649
2) Moving Assistance for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families	1,764	6,686	74%	70%	$809	$821
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	137	215	96%	99%	-	$427

Each program reported an average of three business days to approve an application.

January - December 2009	Moving Assistance	Rental Subsidy	Emergency Assistance
Homeless/At-Risk Families	2,103	58	5,263
Female	3,797	105	9,281
Male	2,568	91	7,084
Hispanic	2,427	85	9,393
African American	3,510	81	6,109
White	162	23	433
Asian/Pacific Islander	99	2	178
Native American	6	2	9
Other	161	3	143
15 and below	3,978	121	7,075
16-24	641	11	1,300
25-49	1,738	64	2,702
50+	8	-	16

1) Moving Assistance (MA) for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families

Successes: During this past quarter through the MA program, a total of 345 families received financial assistance to secure permanent housing and/or received assistance for one or more of the following: a) utility turn-on fees; b) truck rental; and c) appliance purchases (stove and/or refrigerator).

Challenges: Finding safe and affordable housing is a big challenge for low-income families in Los Angeles County.

Action Plan: Utilize and promote the use of websites such as the Los Angeles County Housing Resource Center to assist families in locating safe and affordable housing.

Client Success Story: With financial assistance received through the MA program, a mother was able to secure permanent housing for herself and her daughter. Now that the family has resolved the housing issue, the mother is focusing on job search and education.

2) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families

Successes: This program has provided rental subsidy assistance to 58 families for this quarter.

Challenges: Due to budget constraints, this program was terminated for new program applicants effective February 28, 2009.

Action Plan: The action plan is to continue assisting families that were approved prior to the termination of this program (2/28/09).

Client Success Story: A CalWORKs family who became homeless due to a domestic violence situation accessed GAIN supportive services after resolving a CalWORKs program sanction with the assistance of the participant's HCM. The participant found permanent housing from a listing the HCM provided to her from the Socialserve.com/restricted area search. The participant qualified for Permanent Homeless Assistance, Moving Assistance and the 12 Month Rental Subsidy Program. Through the collaborative efforts of the DPSS HCM, the Housing Resources Eligibility Unit, GAIN and LAHSA (shelter), this family was able to move from a DV shelter into permanent housing.

3) Emergency Assistance to Prevent Eviction (EAPE) for CalWORKs Non-Welfare-to-Work Homeless Families

Successes: Through the EAPE program, a total of 1,089 families at-risk of homelessness received assistance to maintain their current housing and/or maintain their utility services this quarter.

Challenges: Due to the high volume of applications for EAPE, funding is always a challenge.

Action Plan: DPSS continues to evaluate families requesting assistance with past-due rent and/or utilities for the State-approved Homeless Assistance Arrearages Payment program in order to leverage HPI funds.

4) Housing Locators - DPSS

Goal: Assist families to locate and secure permanent housing.
Budget: $1.93 million (DPSS CalWORKs funding)

Table A.3: Housing Locators Measures
FY 2008-09, through December 31, 2008

(unduplicated count)	FY	Cumulative
Homeless Families	471	1,685
Housing (permanent)	210	573
Number of referrals to Program	471	1,685
Average time to place family (days)	60-180	60-180

Successes: Through the assistance of the Housing Locators, 210 families were placed into permanent housing during October-November 2008. No placements were made in December 2008.

Challenges: Due to budget constraints, the Housing Locators contract has been officially terminated effective December 15, 2008. Referrals to the Housing Locators program ended effective October 15, 2008.

Action Plan: The Housing Locator's program contract was terminated effective December 15, 2008.

5) Skid Row Families Demonstration Project

Goal: Locate 300 families outside of Skid Row and into permanent housing.
Budget: $9.212 million (Board Approved Funding)

HPI funding for this project ended on December 18, 2009.

Table A.4: Skid Row Families Demonstration Project Participants and Services
FY 2009-10, through December 31, 2009

(unduplicated clients)	Cumulative (3/31/09)		Cumulative
Homeless Families	300	Moving assistance	175
(individuals)	1,084	Eviction prevention	40
Female	273	Housing (emergency/transitional)	300
Male	27	Housing (permanent)	241
		Rental subsidy	33
Hispanic	68		
African American	187	Education	15
White	12	Job training/referrals	65
Asian/Pacific Islander	3	Job placement	14
Native American	-	Section 8	77
Other	30		
		Case management	275
15 and below	619	Life skills	456
16-24	80	Mental health/counseling	53
25-49	295	Transportation	224
50+	15	Food vouchers	390
		Clothing	18

Program Specific Measures		Cumulative
Number of families enrolled in project	300	300
Number of families relocated from Skid Row area within 24 hours	-	-
Number of families placed into short-term emergency housing	-	300
Number of adults who received referrals to community-based resources and services	386	420
Number of children who received intervention and services	679	850
Number of families who received monitoring/follow up after 6 months case management	353	64
Number of families no longer enrolled (termination or dropped out of program)	59	50
Number of families who received an eviction notice during the last 3 months	30	-
Number of families who lost their permanent housing during the last 3 months	6	-

Emergency Housing/Case Management	Quarter
Average length of stay in emergency housing:	-
Most frequent destination (permanent housing):	-
Case management (level 2)	
Average number of case management hours for each participant per month:	116 hours
Total case management hours for all participants during current reporting period:	348 hours
Number of cases per manager:	3 cases

Longer-term Outcomes	6 mo	12 mo
Continuing to live in housing	3	221
Obtained employment	34	
Maintained employment	55	
Enrolled in education program/school	42	
Completed high school/GED	4	
Case management	224	
Mental health	50	
Substance abuse treatment (residential)	5	
Reunited with family	176	

Additional measures to be provided after close of program (report forthcoming):

- Gainful employment - (Number of individuals who obtained employment)
- Access to appropriate and necessary mental health or substance abuse treatment - (Number of individuals who received mental health services, Number of individuals who received substance abuse treatment)
- Educational stability for children - (Number of children)
- Socialization/recreational stability for children - (Number of children)
- Services to assist domestic violence victims - (Number who received domestic violence services/counseling)

Successes: A total of 300 families were referred by the Skid Row Assessment Team to Beyond Shelter and the Skid Row Families Demonstration (SRFD) Project. Beyond Shelter placed 241 of 300 participant families into permanent housing, primarily with the assistance of a Housing Authority of the City of Los

Angeles (HACLA) Section 8 subsidy. The majority of these families have remained in permanent housing for at least 12 months. As of December 31, 2009, 221 families have successfully completed 12 months in permanent housing. During the current reporting quarter, seven families completed 12 months and three families completed 7 to 12 months. Only seven families have reported to Beyond Shelter that they were evicted from their apartments and have returned to homelessness. Each incidence of eviction was a result of a crisis, including mental health issues, substance abuse, or domestic violence. A total of 59 of 300 families were terminated from the program for non-compliance or loss of contact, prior to a move into permanent housing.

The current focus of the SRFD Project remains on assisting families with stabilizing in permanent housing. Presently, there are three active cases at the end of the second quarter and case managers have continued to provide specialized, individualized, and intensive support for each family. With most of the families' cases now closed or terminated from the program, the case manager's task has been to provide support to previous clients returning for assistance with public social services, childcare referrals and community resources such as food banks. Former participants have also needed guidance regarding available resources for employment, including at least one client who Beyond Shelter was able to link with the Transitional Subsidized Employment (TSE) program through the Department of Public Social Services (DPSS). With support of their former case managers, this quarter several families were assisted with the HACLA annual recertification process. These families needed assistance to the extent that they may have lost their Section 8 vouchers without direct and specific guidance through the process.

Challenges: HACLA recently began sending notices to many successfully housed clients indicating that their Section 8 voucher will be re-issued to them for a smaller-sized unit, unless they opt to remain in their current unit and pay the higher tenant portion of rent. The higher portion of rent can increase to as much as triple the amount of rent the family is able to pay. If a family were to remain in their current unit, they would not be able to afford the rent and would certainly be evicted and, quite probably, become homeless again. Approximately 79 of the 241 families who moved to permanent housing will receive notice of a change in the formula during recertification this year and will be required to relocate. The majority of these families faced many barriers to permanent housing when they entered the SRFD Project, and will experience similar barriers to obtaining subsequent housing even if they do accept the "down-sized" Section 8 voucher. Barriers to housing that these families face include: multiple past evictions, poor credit, poor negotiating skills, and poor landlord references. Furthermore, their current landlords legally have 21 days to return their security deposits, less cleaning costs and any damages incurred beyond normal wear and tear to the apartment. Move-in costs will inevitably become a barrier to relocation. Without housing counseling or a housing relocation specialist to assist them, they will have difficulty locating property owners who accept Section 8 vouchers, and they will have a difficult time negotiating their leases.

If forced to relocate, Beyond Shelter anticipates that many of these families will be unable to utilize their Section 8 vouchers, will have them expire, and will ultimately become homeless again. These families are in need of help, but unfortunately the SRFD Project contract has ended and Beyond Shelter is not currently staffed to fully assist them with the relocation process.

Action plan: Beyond Shelter case managers operating under other government contracts are providing support to at least four former clients who have contacted Beyond Shelter regarding their HACLA voucher re-issuance. At this time, the support consists mainly of guiding them to respond to all HACLA correspondence, so that they are not automatically terminated for failure to respond. Because many of the families are extremely dysfunctional, even the simplest steps in the Section 8 recertification process are difficult to follow; most must be provided with clear and concise guidance. Case managers have helped them understand what they are reading, and have directed them on how to respond to HACLA immediately. They have also referred clients to Legal Aid to keep them informed of the legal process. Additionally, case managers are referring families to their local L.A. City Homelessness Prevention and Rapid Re-housing (HPRP) programs to determine their eligibility for homeless prevention financial assistance, which could potentially provide relocation assistance. With the help of a Housing Specialist, however, to find landlords willing to participate in the Section 8 Program and willing to rent apartment units to families with prior evictions, poor credit, and histories of homelessness, it is anticipated that the majority of these families will lose their Section 8 vouchers and become homeless again.

Client Success Story: Client D is a 54-year-old African American male, with custody of his five-year-old grandson. His grandson's mother has been incarcerated since her son's birth, and his father was

murdered. Prior to this episode of homelessness, Client D was very successful; he completed high school, took college courses in psychology, and worked over 15 years in social services. Client D and his grandson became homeless after things did not work out between him and his girlfriend, and they were asked to leave the apartment they shared. They moved from family and friends to motels, but his main concern was establishing a stable environment for his grandson. Through DPSS, they were placed in a motel but eventually that assistance was exhausted. Desperate, and living in the streets, D sought assistance in Skid Row. They were enrolled into the SRFD Project in July 2007 and were immediately placed into a motel. At the time of their arrival, the family's service needs intensity level was assessed at high intensity due to D being a single grandfather with a child under 12.

The family was soon moved into a master-leased apartment (MLA), which provided them with a stable home environment. Client D was assisted with the Section 8 Housing Choice Voucher application with HACLA and was provided tenant education. Prior to moving into permanent housing, the family's service needs were re-assessed to low intensity due to the stability they achieved while living at the MLA. Utilizing their Section 8 voucher, and with guidance from a Housing Relocation Specialist, Client D signed a lease with the property owner and converted his one-bedroom MLA to permanent housing in May 2008.

Client D's main motivation for finding permanent housing has been to provide a safe home for his grandson. The client battles with high blood pressure, kidney problems, and severe arthritis and receives regular medical treatment. Although his ailments are difficult to deal at times, the client provides his grandson with a safe and loving environment, and constant stimulating and educational activities. His grandson began school last fall and is thriving in his new environment. Beyond Shelter provided guidance and assistance with the SSI application for the client to receive state disability benefits for his medical conditions, and after approximately one year, he was approved to receive SSI benefits.

6) Multi-Disciplinary Team Serving Families
Budget: $494,000 (Ongoing Funding)

Table E.5: Multi-Disciplinary Team
FY 2009-10, through March 31, 2010

(unduplicated clients)	FY		FY
Homeless Families	240	Job training	3
(individuals)	724	Job placement	1
Female	458	Housing (transitional)	25
Male	266	Housing (permanent)	6
		Moving assistance	1
Hispanic	195	CalWORKs	11
African American	472		
White	68		
Asian/Pacific Islander	12	Case management	417
Native American	5	Health care	268
Other	21	Mental health care	105
		Transportation	14
15 and below	394		
16-24	80		
25-49	233		
50+	17		

Case management (level 2)	
Average number of case management hours for each participant per month:	3 hours
Total case management hours for all participants during current reporting period:	1,206 hours
Number of cases per manager:	16 cases

The Skid Row Assessment Team (SRAT) originated as a result of a Board motion in December 2004. It is a collaborative between the County departments of Children and Family Services (DCFS), Public Social Services (DPSS), Mental Health (DMH), and Public Health (DPH). On July 1, 2009 the SRAT moved into the Family Assessment Center located at the Center for Community Health Downtown Los Angeles. The SRAT is committed to attaining the goals of assuring child safety, providing ongoing case management and enforcing the zero tolerance goal for families on Skid Row. The SRAT is excited about the new opportunities that have been identified during the collaboration between County departments and the community agencies that will assist Skid Row families in the care and protection of children.

Successes: During this third quarter, the SRAT encountered 66 new families. In collaboration with the Union Rescue Mission, the Los Angeles Homeless Services Authority and the SRAT, 22 of the new families relocated outside of Skid Row during this period with four of these moving into permanent housing.

During this quarter, a large number of services were provided successfully to the homeless families including the following: 17 families were approved and issued Homeless Assistance by DPSS, 11 families opened CalWORKs cases, 64 health and safety assessments were provided through DPH, 83 individuals were referred for clinical assessments through DMH, and 72 families received child and safety assessments through DCFS with five of the families receiving referrals for Family Preservation or Family Support services. During the month of February, the SRAT initiated a one-month pilot program to assist the SRAT to become more proactive in conducting outreach to the community and agencies in the Los Angeles Continuum of Care. Two members of the SRAT were selected to go out in the community to visit transitional shelters and rental properties across the County to advocate and assist with placing Skid Row families into transitional and permanent housing. Successfully, five families were linked to outside agencies and programs that allowed them the opportunity to relocate from the Skid Row area during the third quarter.

Challenges: The issue of unemployment remains a critical problem, as the families' limited incomes prevent them from moving into permanent housing. The majority of Skid Row families have very low income, with most of them being dependents on CalWORKs. The few families that are employed (9%) do not earn a living wage. The challenge then becomes a lack of availability of low-income housing and/or subsidized housing in which the family is able to sustain.

Action Plan: Ongoing case management services assist families with support and linkage to locate transitional and permanent housing. The staff plans creatively with families to help them gain employment experience and earn a living wage, including referrals to the Subsidized Employment Program at DPSS. Current efforts are underway to link homeless families who have sufficient sustainable income to the Homeless Prevention and Rapid Re-Housing Program for move-in assistance. Plans are also in development through the missions to create new homeless family programs outside of the Skid Row area.

Client Success Story: Client H is a young single mother with an infant son. In December 2009, the family came from Saint Frances Maternity Home in Lynwood, California, where she stayed for four months prior to her son being born. The mother was asked to leave the program once her child was born. She reported she has been homeless since 2007. The family exhausted the Temporary Homeless Assistance but was eligible for the Permanent and Moving Assistance. Client H receives $328 from CalWORKS and $143 in food stamps. She is assigned to a district Homeless Case Manager (HCM) outside the Skid Row area. Client H reports that she has past work experience as a telephone technician and holds a certificate in data entry. Therefore, she is willing to work. In an effort to assist the family, the SRAT transported the family to the district office to complete the necessary forms and to obtain her mail. When she later reported that she had not received her benefits, the SRAT Eligibility Supervisor researched the matter and was able to authorize benefits effective last January. At the same time, Client H reported she had a job interview and inquired about child care. To assist her, the SRAT HCM provided her with appropriate clothing for the job interview. To help with child care, the SRAT linked her to Para Los Niños in the Skid Row area.

With assistance by the DPSS and Union Rescue Mission (URM) case managers, the client found permanent housing. The case managers further worked with the property owner on the paperwork and assisted Client H. in applying for the Moving Assistance through DPSS. She then successfully moved into her apartment in late January. With the support and assistance of the SRAT members and URM staff, this family gained employment and successfully relocated from the Skid Row area into a studio apartment located on in the downtown Los Angeles area.

II. PROGRAMS FOR TRANSITION AGE YOUTH

7 and 8) Moving Assistance for Transition Age Youth

Goal: Assist Transition Age Youth (TAY) to move into and secure permanent housing.
Budget: $3.5 million (One-Time Funding)

Table B.1: Moving Assistance for Transition Age Youth Participants
FY 2009-10, through March 31, 2010

	Total	Probation		DCFS	
		FY	Cumulative	FY	Cumulative
Transition Age Youth	966 (100%)	101 *(new)	459	146 *(new)	**580
Female	557 (58%)	45	195	109	361
Male	409 (42%)	56	264	37	145
Hispanic	235 (24%)	18	112	36	123
African American	672 (70%)	81	329	98	343
White	40 (5%)	2	12	12	28
Asian/Pacific Islander	6 (1%)	-	6	-	-
Native American/Other	-	-	-	-	-
16-24	966 (100%)	101	459	146	506

* During the First Quarter of FY 2009-10, 62 new TAY were enrolled; 179 TAY continued to participate.
**FY 2008-09 total was 360. FY 2007-08 DCFS demographic participant data was duplicative (duplicated total 464); cumulative demographic information includes FYs 2008-09 and 2009-10.

Table B.2: Moving Assistance for Transition Age Youth Services
FY 2009-10, through March 31, 2010

(unduplicated count)	Total	Probation		DCFS	
	FY	FY	Cumulative	FY	Cumulative
Moving assistance	35	2	255	33	237
Rental subsidy	115	8	366	107	538
Housing (permanent)	136	101	412	35	269
Eviction prevention	1	-	-	1	1
Any supportive service+	26	26	127	-	64
Education	38	1	10	37	95
Job training, referrals	-	-	-	-	35
Job placement	5	5	86	-	-
Case management	162	101	459	61	495
Life skills	-	-	-	-	8
Mental health	-	-	-	-	1
Transportation	11	-	-	11	118
Food vouchers	3	-	-	3	46
Clothing	10	-	-	10	82
Auto insurance	1	-	-	1	12

+Probation does not break down supportive service by type, except for job placement.

Table B.3: Longer-term Outcomes for Transition Age Youth
(6 or more months), FY 2009-10, Third Quarter

	Probation	DCFS
Continuing to live in housing	142	46
Continuing to receive rental subsidy	-	7
Obtained employment	15	10
Maintained employment	126	33
Enrolled in educational program/school	-	26
Received high school diploma/GED	-	4

Table B.4: Program Specific Measures for Transition Age Youth
FY 2009-10, through March 31, 2010

	Probation		DCFS	
	FY	Cumulative	FY	Cumulative
Number of new approvals	101	538	85	425
Average cost per youth	$2,210	*$3,806	$3,500	*$2,663
Number of program participants satisfied with program services	202 (of 202)	450 (of 452)	20	155
Number of pregnant/parenting youth placed in permanent housing	13	103	1	72
Number exited housing	39	60	-	324
Number remaining in permanent housing and receiving assistance at 6 months	n/a	n/a	16	94

*Average cost per youth for FY 2008-09; in FY 2007-08, the average cost was $3,816 for Probation.

Probation– Moving Assistance for TAY

Successes: During the quarter, 202 youth were served, and 48 additional youth were placed in permanent housing. The program enables youth to maintain employment, obtain better employment, or continue their educational aspirations while staying out of trouble with the law. The program participants' low recidivism can be attributed to the Transitional Permanent Project (TPP) and support from the TPP coordinator.

Challenges: Challenges continue to be limited vocational possibilities due to the shrinking economy and job market. Funding for educational opportunities are scarce and some probation youth lack motivation and perseverance to seek educational programs that will improve their financial situation in the future. Referrals for participation in County-sponsored employment and educational programs such as the General Relief Opportunities for Work (GROW) program can be challenging due to the lengthy referral process.

Action Plan: Staff will continue to offer support and motivation to encourage clients to enroll in vocational and educational programs. Probation is working with DPSS and Work Source Centers on improving processes for referral and linkages to employment opportunities.

Client Success Story: Client R was released from California Youth Authority in September 2009 after completing a five year sentence. Upon release, Client R contacted the TPP coordinator to inquire about services. He was eligible for program participation, and moved into his apartment in October. He currently resides with his girlfriend and three-year-old daughter. Client R attends barber school in the evenings and works at a construction site during the day. Most importantly, because of this program and assistance provided to him and his family, client R made a positive behavioral change and has cut all ties to his prior gang affiliation. He continues to provide for his family and has not had any new contact with the law.

DCFS – Moving Assistance for TAY

Successes: The program has been successful in reducing the number of homeless youth within the TAY population. However, budget curtailments/shortfalls placed limited range on supportive services that were provided to assist participants with living successfully in permanent housing. During this quarter, 31 youth were newly approved to receive rental assistance. The program provided move-in assistance to 18 youth.

Challenges: The challenges remain basically unchanged as maintaining contact continues to be the most significant obstacle. Additionally, the youth continue to fail at submitting the required documents for approval in a timely fashion. Youth continue to experience difficulty in obtaining as well as maintaining gainful employment.

Action Plan: Staff will continue to encourage youth to maintain contact, establish alternate telephone contact numbers with friends, relatives, and their place of employment (for emergent calls). Staff will encourage youth to enroll in employment assistance programs, such as the California Employment Development Department (EDD), Workforce Investment Agencies, etc.

Client Success Story: A 21-year-old male, former foster youth, was wrongfully terminated from his job. DCFS provided rental assistance to prevent possible eviction, as he sought union representation to regain his employment. Consequently, the youth's employment was restored.

III. PROGRAMS FOR INDIVIDUALS

9) Access to Housing for Health (AHH)

Goal: To provide clients discharged from hospitals with case management, housing location and supportive services while permanent housing applications are processed.
Budget: $3 million (Board Approved Funding)

Table C.1 : Access to Housing for Health Participants and Services
FY 2009-10, through March 31, 2010

(unduplicated count)	FY	Cumulative
Homeless Individuals	18	35
Chronic Homeless	15	104
Homeless Families	2	6
Female	18	62
Male	20	90
Transgender	-	1
Hispanic	5	32
African American	18	67
White	14	51
Asian/Pacific Islander	-	1
Native American	-	-
Other	1	2
15 and below	2	9
25-49	11	53
50+	25	91
Moving assistance	25	78
Housing (emergency/transitional)	34	141
Housing (permanent)	32	94
Rental subsidy	32	94
Eviction prevention	6	4

	FY	Cumulative
Education	3	5
Job training	5	6
Job placement	-	2
General Relief and Food Stamps	2	2
General Relief	3	63
Food Stamps only	-	1
Medi-Cal/Medicare	12	41
Section 8	30	58
Public Housing Certificate	6	16
SSI/SSDI	13	36
	FY	**Cumulative**
Case management	35	142
Health care	38	145
Life skills	35	142
Mental health/counseling	7	35
Substance abuse (outpatient)	1	17
Transportation	9	106
Alternative court	4	4
Social/community activity	9	9
Substance abuse (residential)	1	1

Program Specific Measures	FY	Cumulative
Number of referrals	158	761
Number admitted to program (enrolled)	35	142
Pending applications (quarter)	15	-
Number that did not meet eligibility criteria	117	611
Number of exited clients	5	34
Reduction in Emergency Department visits (12 months post enrollment, n=69)	-	76%
Reduction in number of inpatient days (12 months post enrollment, n=69)	-	85%
Number of new AHH enrollees that have a primary healthcare provider	35	142

Transitional Housing/Case Management	
Average stay at emergency/transitional housing:	151 days
Case management (level 3)	
Average case management hours for each participant per month:	15 hours
Total case management hours for all participants during current reporting period:	810 hours
Number of cases per case manager:	14 cases

Table C.2: Longer-term Outcomes
FY 2009-10, Third Quarter

	6 mo.	12 mo.
Continuing to live in housing	70/72	51/53
Receiving rental subsidy	97%	96%
Enrolled in educational program/school	1	-
Case management	12	10
Health care	12	10
Mental health care	1	4
Reunited with family	-	1

Successes: To date, there are 69 AHH clients that have successfully maintained housing for one year in the program. They had a combined total of 297 Emergency Department visits during the 12 months prior to enrollment in AHH. After enrollment into AHH, the clients had a combined total of 70 Emergency Department visits. The number of Emergency Department visits was reduced by 76%. These 69 AHH clients also had a combined total of 587 inpatient days prior to enrollment in AHH. These clients had a combined total of 86 inpatient days after enrollment into AHH. The number of inpatient days was reduced by 85%.

AHH clients and graduates continue to participate in the monthly meetings which offer resources, health education and community/social supports. The graduation ceremony in February had a high attendance and the clients enjoyed the support and camaraderie. AHH continues to offer a weekly support group, which many clients attend consistently. This weekly support group allows clients to meet others in the program, share resources and gain support. AHH recently implemented individual therapy sessions and the clients have since attended weekly therapy sessions regularly. At the end of this quarter, there were only two unassigned slots left. The project stopped taking new referrals at that time. Staff will continue to process the pending referrals in hand until all 115 slots (total) are utilized.

Challenges: There continues to be challenges in obtaining appropriate referrals for clients that would be suitable for the AHH program. Many of the referred clients do not posses the skills for independent living or require a higher level of care. Many clients present with severe physical and/or psychiatric conditions and are unwilling to access treatment or comply with medication. Additionally, there continues to be challenges in obtaining all necessary and current documentation in a timely manner from clients for submission to the housing authorities.

Action Plan: The AHH Project Coordinator continues to receive referrals and these are being processed in a timely manner. The AHH staff actively review referrals to ensure efficiency. The AHH staff remains fully staffed at this time. The Housing Locator continues to assist to ensure that the housing application is complete and submitted; location and move-in processes are meeting the client's needs and occurring in a timely manner. The case managers and Housing Locator continue to work closely to best assist clients and ensure that they obtain and maintain permanent housing. The AHH staff continues to promote the program with current referral sources and the development of new sources. The staff plans to continue to reconnect with referral sources.

Client Success Stories: Client M is a 49-year-old Spanish speaking Hispanic male. He has been homeless for one year prior to joining AHH and was residing at a shelter. Client M became homeless after not being able to work due to an amputation and other associated medical problems. The client worked in maintenance for 11 years prior to becoming disabled. He has a history of type I diabetes mellitus, anemia, major affective disorder and depression. He also has an amputation above his right leg due to complications of uncontrolled diabetes and was wheelchair-bound at enrollment into AHH. He had a history of uncontrolled diabetes for 16 years and was medically non-compliant. Since enrolling in AHH, he has maintained his medical appointments and is now compliant with medications and sees his primary care physician on a regular basis. Since gaining permanent housing through AHH and receiving his prosthesis, his affect and attitude have improved. His outlook is positive and he no longer reports the need for mental health intervention. The client's depression was situational due to his amputation. Since receiving his prosthesis while in AHH, he no longer reports being depressed. The client shows pride in his home and takes good care of his apartment. He continues to maintain appointments with AHH staff and is in regular contact with his case manager. The client took English classes while in AHH and now has a better understanding of the language. Client M is now able to walk and drive with his prosthesis and has gained greater independence.

10) Benefits Entitlement Services Team for the Homeless (B.E.S.T.)
Budget: $2,000,000 (One-Time Funding)

Table C.3: B.E.S.T Services
FY 2009-10, December 1, 2009 – March 31, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	17	Housing (emergency)	17
Chronic Homeless	210	Housing (transitional)	7
		Housing (permanent)	3
Female	63		
Male	164	General Relief and Food Stamps	3
		Section 8	1
Hispanic	42	SSI	22
African American	118	Transportation	1
White	51	Medi-Cal/Medicare	19
Asian/Pacific Islander	5	Case management	227
Native American	2	Health care	158
Other	9	Mental health care	184
		Recuperative care	17
		Substance abuse treatment (outpatient)	3
16-24	7	Case management (level 3)	
25-49	129	Average hours for each participant	5
50+	91	Total hours for all cases	730
		Average caseload per case manager	40
Program Specific Measures			
Number of initial applications submitted to SSA			24
Number of initial applications approved by SSA			22
Average length of time from participant enrollment date to SSA approval date (days)			55

Successes: The Benefits Entitlement Services Team for the Homeless (B.E.S.T.) project is on target to meet enrollment numbers as of the end of the third quarter. Further, the project and dedicated staff have shown that with coordination and intensive case management the most vulnerable people with multiple illnesses are able to obtain their SSI in a timely manner. B.E.S.T. continues to operate with only one denial among the 20 approvals thus far.

Challenges: One challenge in B.E.S.T. has been finding enough time from psychiatrists for the project. There are so many mentally ill individuals that need care and are in need of benefits.

Action Plan: No action plan is necessary at this time.

Client Success Story: A 58-year-old African American woman living in a park in Pomona was identified by the Volunteers of America (VOA) El Monte outreach team. She had not bathed in months, had poor eye contact, and she was apprehensive and extremely guarded. After months of outreach, she finally agreed to come to the B.E.S.T. El Monte site, but she would only wait outside of the office due to her severe paranoia. The VOA staff transported this individual to appointments for weeks. Eventually, the onsite psychiatrist gained this individual's trust. Through an assessment, the psychiatrist found that she had schizophrenia and had been the victim of extreme abuse at the hands of her parents and then as an adult at the hands of her ex-husband. She had been homeless for the last 21 years and had not been treated for any of her mental health or physical health conditions. The psychiatrist began to gain her trust and started treating her with medication for her schizophrenia. She also began receiving primary care through the B.E.S.T. project for the first time in five years. After being on medication for just two months, she was able to take the bus without any assistance and even wait in the lobby of the VOA office. The VOA staff worked with the B.E.S.T. case manager to obtain a valid California identification, birth certificate, disabled bus pass and other items that helped rebuild her life. Her SSI application was filed in February, and she received approval three weeks later. Upon completion of the project, she was transitioned to Tri-City Mental Health for ongoing care. She also opened up a bank account with assistance from the B.E.S.T. case manager, and she is now permanently housed in an affordable unit in the City of Claremont. Her mental health services are close to where she lives, and she is thriving for the first time in 21 years.

11) Center for Community Health Downtown Los Angeles
Budget: $186,000 ($76,000 expected for Ongoing Funding)

Table C.4: Center for Community Health Downtown Los Angeles (CCH)
FY 2009-10 through March 31, 2010

(unduplicated clients)	FY		FY
Homeless Individuals	4,661	Housing (emergency)	48
		Housing (transitional), average stay 90 days	60
Female	1,201	Housing (permanent)	76
Male	3,460	Rental subsidy	1
Hispanic	1,020	General Relief and Food Stamps	16
African American	2,414	Medi-Cal/Medicare	13
White	539	Section 8	12
Asian/Pacific Islander	58	SSI/SSDI	33
Native American	14	Case management	418
Other	616	Health care	4,661
More than one race/ethnicity may be selected		Mental health care	201
		Recuperative care	1
16-24	185	Substance abuse treatment (outpatient)	8
25-49	2,356	Substance abuse treatment (residential)	2
50+	2,120	Transportation	12
		Other	25
Case management (level 3)			
Average number of hours:	1	Job training/referrals	18
Total case management hours:	720	Education	1
Number of cases per manager:	86		

Successes: The integration of services at CCH continues to effect outcomes as evidenced by the increase in placement of clients into transitional and permanent housing during the third quarter. The data also shows that social workers are having a greater success rate with these types of placement as opposed to emergency housing (which had been the predominant placement site). Job training and referrals, as well as benefits assistance has also increased at a faster pace than the prior two quarters.

Challenges: The integration of substance abuse services continues to present a challenge. The number of referrals for assessment improved but actual placement into programs did not. During the quarter discussions continued regarding possible solutions, and it was suggested that on site individual and/or group treatment (as opposed to assessment alone) be considered.

Action Plan: A meeting between DPSS, Homeless Health Care Los Angeles, and CCH leadership discussed the feasibility of providing substance abuse treatment on site. This idea was proposed during a conference call in March between DPSS, the CEO and CCH.

Client Success Story: The Social Services Team at CCH was able to assist a 52-year-old disabled female who was abandoned by her children after relocating from the Philippines to Los Angeles. The client initially arrived in Los Angeles last fall soon after she sustained a stroke that left her with residual weakness and an inability to ambulate without the use of a cane. The client was planning to enter the United States in order to live in closer proximity to her son and daughter, both of whom were residing in Los Angeles. Her son had been designated as her sponsor here, and according to INS regulations the sponsor is financially responsible for taking care of her (thus making her ineligible for public benefits for five years). Unfortunately, when she arrived at LAX her son/sponsor was not there and would not return calls from her. After several weeks, the Adult Protective Services (APS) became involved and placed her in a local mission in downtown Los Angeles.

A few months later the patient was admitted to Recuperative Care after sustaining a fall requiring hospitalization. The client was subsequently referred to the MSW at CCH. The MSW left multiple messages with the client's son and was also able to reach her daughter, but the children declined to reunite with their mother or offer any assistance. The client became very depressed due to the abandonment by her children and the resultant homelessness. Fortunately the MSW was able to escort the client to DPSS where the DPSS case worker indicated that a letter of refusal from SSI and an inquiry

to INS documenting the abandonment by her son would allow for an adjustment to her benefits status. Once this was completed, the client was awarded General Relief along with food stamps. Since the patient was medically cleared for discharge from Recuperative Care, the MSW also assisted the client in obtaining three month emergency housing and placement in a two-year transitional housing program. While the client resides in the housing program, the CCH MSW will continue to assist with placement into permanent housing and supportive counseling twice a month. The patient is much improved and doing well.

12) Co-Occurring Disorders Court (CODC)

Goal: Assist dually diagnosed adult defendants in receiving comprehensive community-based mental health and substance abuse treatment.
Budget: $200,000 (HPI On-going Funding; pass through for DMH)

Table C.5: Co-Occurring Disorders Court (CODC) Participants and Services
FY 2009-10, through March 31, 2010

(unduplicated count)	FY	Cumulative		FY	Cumulative
Chronic Homeless	21	87	Education	1	16
Homeless Individuals	19	24	Job training/referrals	10	36
Transition Age Youth	3	4	Job placement	5	6
Female	20	62	CalWORKs	1	2
Male	23	54	General Relief (GR,FS)	3	17
			General Relief	6	6
Hispanic	3	11	Food Stamps only	1	4
African American	33	90	Medi-Cal/Medicare	-	32
White	6	11	SSI/SSDI	9	39
Asian/Pacific Islander	1	1	Shelter Plus Care	-	5
Other	-	2			
16-24		7	Alternative court	42	87
25-49		69	Case management	41	86
50+		39	Health care/medical	41	64
			Life skills	41	82
Eviction prevention	-	2	Mental health/counseling	41	86
Housing (emergency)	-	8	Social/community activity	30	50
Housing (transitional); avg. 210 days	7	54	Substance abuse (outpatient)	8	71
Housing (permanent)	9	11	Substance abuse (residential)	44	62
Rental subsidy	13	46	Transportation	41	86
Moving assistance	-	2	Clothing/hygiene	40	62
Longer-term Outcomes (six or more months)					
Continuing to live in housing					48
Receiving rental subsidy					11
Enrolled in educational program, school					5
Obtained/maintained employment					8
Case management					48
Health care					48
Good or improved physical health					36
Mental health/counseling					48
Good or improved mental health					41
Substance abuse treatment (outpatient)					40
Substance abuse treatment (residential)					23
No drug use					23
Reunited with family					1
Emergency Housing/Case Management					
Case management (level 3)					5 hours
Total case management hours for all participants during current reporting period:					291 hours
Number of cases per case manager:					6 cases

Successes: During the third quarter of FY 2009-10, three CODC clients graduated from the court program and received a dismissal of their criminal charge(s). To date, sixteen clients have now graduated from the CODC program, with another three individuals expected to graduate in April 2010.

Given the growing number of graduates, a special Alumni Group has been developed by a Consumer Employee employed by Special Service for Groups (SSG) Central Mental Health (CMH) to reinforce the advances made by the CODC graduates and to offer continued support as they move forward in their recovery. The Alumni Group entails a voluntary monthly meeting for the CODC graduates who have chosen to continue to participate in program development, mentoring, and/or volunteer support.

SSG has increased the number of Consumer Employees to five. Four of these Consumer Employees are CODC graduates and the fifth is expected to graduate during the summer of 2011. Consumer Employees engage in a variety of tasks that support treatment and long-term stability for the CODC clients. For example, they provide orientation sessions for new clients and assist in the program's therapy groups. Linkages to community-based programs such as Twelve Step and Recovery meetings, free meals, and other resources offered throughout the downtown Los Angeles area -- are also provided to the clients by the Consumer Employees. In conjunction with the *Dress for Success* program, the Consumer Employees assist clients who are seeking employment with obtaining professional attire. Finally, Consumer Employees publish a monthly SSG newsletter for and by CODC clients to keep members informed about their program, community, and each other.

The Antelope Valley Rehabilitation Center (AVRC) component of the CODC program has graduated 29 clients from its 90-day residential co-occurring disorders treatment program. Collaboration between SSG/CMH and AVRC continues to be strong and the clients continue to report positive experiences at the AVRC facility.

SSG's CODC *Step Up Program* at Mt. Carmel continues to be an integral part of treatment, helping clients transition back into the community following their first three months at AVRC. Clients report that this program allows them to further establish relationships with the individuals they began treatment with at AVRC. This has resulted in enhanced continuity of care and increased engagement in the CODC program.

For those CODC clients who have completed the initial phases of treatment and are seeking permanent housing, DMH has partnered with SSG to provide assistance with completing housing applications and exploring housing resources and options. SSG and DMH hosted a panel presentation for the CODC clients that featured speakers from the DMH Housing Division, Skid Row Housing Trust, and Comprehensive Housing Information & Referrals for People Living with HIV/AIDS (CHIRP/LA). The workshop was well-attended by 25 CODC clients who have been residing in transitional housing or sober living homes in the community. It was also very well-received, with 89% reporting that the presentation was "very helpful." SSG and DMH will continue to develop working relationships with housing providers in order to optimize the CODC clients' ability to secure permanent housing.

Table C.6: Program Specific Measures	FY	Cumulative
Number of clients screened for enrollment	167	571
Number of clients accepted for observation	44	122
Total number of clients enrolled	27	93
Number of clients pending enrollment (quarter)	12	-
Number of clients not meeting Program criteria	86	276
Number of clients rejecting/dropping out prior to enrollment	34	133
Number of clients lost during follow-up process	2	8
Number of participants in ER/crisis stabilization while enrolled in program	11	32
Average length of hospital stay (days)	11	-
Number of participants who have a primary healthcare provider while enrolled	29	82
Number of participants with new arrest(s)	14	35
Misdemeanor:	3	6
Felony:	11	25
Number of participants in jail	14	36
Average number of days in jail.	16	(FY 08-09) 25

FY 2007-08 average number of days in jail: 36

Challenges: The treatment schedule at AVRC continues to be light and there has been no update from facility management regarding an expected time frame for the adoption of the Matrix system of care. The proposed Matrix is expected to increase the amount of treatment provided to clients. This issue is being

addressed by SSG and AVRC staff by preparing clients more directly for the increase in their next phase of treatment following their completion of the AVRC program.

The curtailment of the Proposition 36 Court continues to pose a challenge for the CODC program with regard identifying cases. In response to this challenge, the CODC Team agreed to expand its client outreach efforts to include the Pasadena Superior Court. The outreach expansion was initiated in March 2010 and generated one new client for the CODC program. The CODC Team will continue to explore various outreach options with the goal of promoting service delivery to individuals who would benefit from participating in this specialized treatment court.

Action Plan: Energy continues to be focused on grant writing to access new funds to make improvements in the treatment program. The SSG development team is working closely with the Countywide Criminal Justice Coordination Committee (CCJCC) on numerous grants to enhance current programs and services and to expand services to additional clients.

A CODC Expansion Grant funded by the Department of Justice/Bureau of Justice Assistance is expected to be approved by the County Board of Supervisors in April 2010. This grant will fund "Project Employ," which is designed to provide intensive employment supports and services to the CODC clients thereby increasing social reintegration and self-sufficiency and reducing recidivism. CODC participants who wish to enter or return to the workforce will receive employment-focused group counseling and work-readiness skills-building, including: resume preparation, mock interviews, and wardrobe assistance. Once employed, the CODC clients will receive individual coaching, worksite supports, and retention assistance. Project Employ will also provide technical assistance and support to businesses that employ the CODC clients. A Supportive Employment Specialist has been hired and the program is expected to begin in May 2010.

Client Success Story (by client): My name is D, and I am an addict. I've been using since 15 years old. It started with alcohol, then on to weed. By the time I was 19 years old, I was hooked on crack. I used crack all the way until I was 30. In 2002, I found myself using again. I went to more programs or should I say "treatment." Prop 36 Court felt that because of my medications I needed to come to Judge Tynan's Court. They put me in SSG. During the first eight months I still kept getting Prop 36 testing. Then the treatment team at SSG decided that I should go to Acton. My first three weeks I hated it. Then something happened. I became part of the treatment center. I made a lot of friends who became part of my support group when I got out. I became more willing because I was very unhappy with the way I was living my life before Acton. When I got out, it wasn't easy. But I asked God every morning for my life to be with his and not mine. That is how I made it through each day. I stayed away from old friends and wet (slippery) places. Thank you SSG for giving me another chance to prove myself without even asking. I now have a year of sobriety -- and if you look at the time, you will see how long it took.

13) DPSS General Relief (GR) Housing (Rental) Subsidy and Case Management Project

Goal: To assist the homeless GR population with a rental subsidy. In addition, coordinate access to supportive services and increase employment and benefits to reduce homelessness.

Budget: $4.052 million (HPI On-going Funding)

Table C.7: DPSS GR Housing Subsidy and Case Management Project Measures
FYs 2008-09 and 2009-10, through March 31, 2010

			Cumulative
Chronic Homeless	742	Education	34
Homeless Individuals	1,991	Job training/referrals	764
		Job placement	237
Female	1,062		
Male	1,671		
		SSI/SSDI	256
Hispanic	330	Section 8	6
African American	1,812	Veteran's	1
White	508		
Asian/Pacific Islander	43		
Native American	20	Case management	3,198
Other	20	Health care	930
		Life skills	448
16-24	303	Mental health/counseling	805
25-49	1,838	Substance abuse (resident)	21
50+	592	Substance abuse (outpatient)	143
	Cumulative	Transportation	974
Rental (housing) subsidy*	3,198	Recuperative care	3
Moving assistance	2,372	Social/community event	1

Longer-term Outcomes (point in time)	**6 mo.**	**12 mo.**	**18 mo.**
Receiving rental subsidy	462	222	202
Obtained employment	11	-	-
Maintained employment	20	-	-
Enrolled in educational program, school	9	-	-
Case management	462	222	202
Health care	27	21	25
Mental health/counseling	12	7	12
Substance abuse treatment (outpatient)	6	1	1

**Total number served from July 2006- December 2009*

Table C.8: DPSS GR Housing Subsidy and Case Management Project Measures
FY 2009-10, Third Quarter

	Third Quarter	**To date**
Number of applications received	288	2,700
Average number of business days to approve	25	-
Average amount of rental subsidy	$292	$292
Number of individuals re-entering program	3	143
Number of SSI approvals	32	244
Percent of SSI approvals	6.23%	(FY 2008-09) 7.94%
Number of individuals disengaged from program	84	979
Case Management (level 3)		
Average case management hours for each participant per month:		5 hours
Total case management hours for all participants during current reporting period:		3,987 hours
Number of cases per case manager:		74 cases

Successes: During this quarter, there were 11 job placements and 32 SSI approvals. An evaluation study of the pilot's outcomes showed that the average length of stay for participants in the pilot program was about seven months. Compared to a control group, employable participants enrolled in the pilot project were two times more likely to find jobs. The total number of active subsidies for the last month of the quarter was 866, which is 14 short of the maximum allotment.

Challenges: Participants were relocating or moving out of their rental units without notifying the case-carrying Eligibility Worker or the GR Housing Case Manager (GRHCM), and their rental subsidies are

issued to their previous landlords which created more work for staff recouping the money from landlords and processing the documentation from the new landlord in a timely manner.

Action Plan: The following were the recommended actions:

- Staff to explain and remind the participants of their reporting responsibilities;
- Encourage participants to provide valid contact numbers; and
- Staff to increase the frequency of contacts with participants to a minimum of twice a week.

Client Success Stories:

Client L applied for General Relief and Food Stamps in July 2006. His health deteriorated, and he became mentally challenged and homeless. He applied for a Housing Subsidy in May 2008 and moved to a new place in June. Client L never missed his mental health assessment appointments, including treatment services. In April 2010, Client L received his initial SSI check from SSA. He was very thankful to the Lancaster GRHCM staff for all their assistance, hard work, and encouragement provided to him.

Client A was a former office manager before she left California to help her ailing mother. When she returned last year to Los Angeles County, she was homeless and unemployed. Client A applied for a Housing Subsidy and was placed in housing. At the same time, she was placed in the FASTRAK employment services component of General Opportunities for Work (GROW). She was hired as an Assistant Manager with the Ross Department Store last month. She acknowledged the support and assistance provided by Metro Special's GRHCM program in helping her to become self-sufficient again.

14 and 15) Homeless Release Projects (DPSS-DHS and DPSS-Sheriff)

Goal: Identify individuals scheduled for release who are eligible for DPSS administered benefits.
Budget: DPSS-DHS: $588,000; DPSS-Sheriff: $1.171 million (On-going Funding)

Table C.9 Homeless Release	**Total FY**	**DPSS-DHS**		**DPSS-Sheriff**	
(unduplicated count) FY 2009-10, through March 31, 2010		**FY**	**Cumulative**	**FY**	**Cumulative**
Homeless Individuals	1,935	734	*1,050	1,201	*5,851
Female	604	49	138	555	1,299
Male	1,274	173	498	1,101	1,755
Transgender	2	-	-	2	7
Hispanic	617	67	190	550	1,093
African American	756	79	243	677	1,389
White	421	57	164	364	680
Asian/Pacific Islander	55	11	19	44	49
Native American	6	3	5	3	6
Other	28	5	15	23	45
16-24	327	6	24	321	599
25-49	1,240	123	343	1,117	2,029
50+	316	93	269	223	433
Housing (emergency)	91	40	115	51	269
Average stay (days)	12	13	-	11	-
CalWORKs (approvals)	10	1	2	9	59
General Relief (w/FS)	675	80	370	595	2,797
General Relief only	105	18	95	87	390
Food Stamps only	10	1	6	9	58
SSI/SSDI	31	-	-	31	56
Veterans' benefits	7	-	-	7	13

*Demographic information not available for FY 2007-08. Cumulative demographic information includes FYs 2008-09 and 2009-10.

Table C.10 Program Measures	Cumulative Total	DPSS-DHS		DPSS-Sheriff	
		FY	Cumulative	FY	Cumulative
Total referrals received	10,577	275	1,087	1,614	9,490
Total referrals accepted	6,892 (66%)	102	526	1,165	6,366
Of the total referrals accepted:					
Total approved	680 (FY)	100	*233	580	3,226
Total denied	143 (FY)	32	*218	121	254
Total pending release:	1,730 (QTR)	2	-	1,728	-
Releases/discharges	1,047	65	304	610	743
Number of applications					
Food Stamps	288	43	44	195	244
General Relief	3,162	57	432	373	2,730
CalWORKs	50	-	1	5	49

**Information not available for FY 2007-08.*

DPSS-DHS Homeless Release Project

Successes: Thirty-two individuals were discharged from the County facilities and received Food Stamps, General Relief or CalWORKs benefits.

Challenges: The private hospitals continued to have an extremely low number of referrals and only two approvals since the expansion to private hospitals on September 29, 2008.

Action Plan: Program staff has offered training to assist the private hospital staff on the use of the DPSS screening tool and is waiting for private hospital staff to respond to the Department's request.

DPSS-Sheriff Homeless Release Project

Successes: Priority list interviews done at Inmate Reception Center (IRC) rather than at Men's Central Jail attorney room has increased significantly. The priority list allows the Eligibility Worker (EW) to interview more inmates in less time.

Challenges: The number of referrals has increased. However, due to inmate court dates, Custody Assistant shift changes and lock downs, the inmates are being released before DPSS staff has a chance to interview them.

Action Plan: Program staff has discussed this issue with the County Sheriff's Department (LASD). However, court dates, lock downs and individuals being released directly from the court are beyond the control of the LASD staff.

16) Homeless Recuperative Care Beds

Goal: Provide recuperative care services to homeless individuals being discharged from County hospitals and assist participants with accessing transitional or permanent housing, ongoing health care, and other resources and supportive services.

Budget: $2.489 million (One-Time Funding)

Table C.11 : Homeless Recuperative Care Beds Participants and Services
FY 2009-10, through March 31, 2010

(unduplicated count)	FY	Cumulative		FY	Cumulative
Homeless Individuals	206	486	Housing (permanent)	20	65
			Housing (transitional)	48	120
Female	30	73	Housing (emergency)	9	48
Male	175	410			
Transgender	1	3	General Relief only	-	11
			Medi-Cal/Medicare	-	7
Hispanic	84	130	SSI/SSDI	-	7
African American	56	124			
White	52	102	Case management	206	486
Asian/Pacific Islander	4	6	Health care	206	486
Native American	3	3	Life skills	-	12
Other	7	24	Mental health/counseling	-	1
(race doesn't include two quarters; updating)			Recuperative care	206	486
16-24	-	4	Transportation*	-	70
25-49	104	243	Substance abuse (outpatient)*		
50+	102	239			

Program Measures	FY	Cumulative
Number of patients referred for recuperative care beds	281	637
Number of patients admitted to recuperative care services	206	486
Number of patients who were discharged from recuperative care services	183	461
Number of patients who were assigned to a primary health care provider during recuperative care stay	206	486
Average length of stay for patients in recuperative care program (days)	22	30
Percent decrease in ER visits 6 months after receiving recuperative care	-	28%
Percent decrease in inpatient admissions 6 months after receiving recuperative care	-	70%

Emergency Housing/Case Management	
Average stay at emergency/transitional housing:	24 days
Level 3 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	6 hours
Total case management hours for all participants during current reporting period:	480 hours
Number of cases per case manager:	25 cases

Successes: The Recuperative Care program served 486 unduplicated individuals to-date, from April 2008 through March 2010. At the end of this quarter, a six-month pre- and post- analysis was conducted on the participants served who received recuperative care services at least six months prior to the analysis. For these recuperative care participants, a pre-/post- comparison showed **a 28% reduction in emergency room (ER) visits and a 70% reduction in inpatient hospitalizations**. In addition, there was **a 47% decrease in the number of participants who utilized the ER and a 71% decrease in the number of participants who required hospitalization**.

Challenges: The most significant challenge continues to be the lack of available housing resources that clients can access upon discharge from recuperative care. A majority of clients do not have a regular income source. In the previous quarter, the provider had to reduce the number of transitional beds they operated due to the loss of private funding. The reduction in accessible housing/placement resources significantly impacts efforts to discharge recuperative care clients into more stable housing environments. Some clients are not able to access housing resources that have requirements on an applicant's behavioral history or restrictions related to legal status which presents additional challenges. Given the use of manual data collection and reporting methods, various challenges continue in these areas, however, improvements in data quality and reliability are progressing.

Action Plan: JWCH is setting up two project sites for the HPI-funded homeless SSDI/SSI benefits project at their recuperative care sites. This will bring on-site access to these services for recuperative care clients, which may expedite clients' access to stable income for eligible individuals and increase opportunities for obtaining permanent housing. In addition, efforts to link recuperative care services with permanent housing opportunities are continuing. Eligible participants who are frequent users of DHS inpatient and/or ER services have been referred to the Access to Housing for Health (AHH) program with some success. Additional efforts in assisting clients with reconnecting with their families are stressed. The recuperative care director at JWCH has oversight responsibilities for program activities and is continuing to work on addressing the identified challenges, including development of a database/data collection system for these services. DHS staff will continue to meet with JWCH management staff to discuss program status and progress and provide assistance as needed. Improvements have been noted for data collection and reporting activities, however further progress is needed and DHS will continue to work with the program director.

Client Success Story: A 61 year-old Native-American male was hospitalized due to cellulitis on his right leg, he also had gastro-intestinal bleeding and severe anemia. The individual also had been chronically homeless for over a year prior to entering the hospital. He was referred by Harbor-UCLA Medical Center and was admitted as a client into the Recuperative Care program at Bell Shelter in January 2010. The client had been living around the Los Angeles River since he lost his job as a forklift operator and instructor with a defense contractor in Los Angeles and had not been able to find employment for the last 10 years. Although he has family, he explained that there were too many relatives living in one home with little-to-no space for him. He has three children, all adults, whom he did not wish to burden, as they have their families of their own.

Upon arrival at the Recuperative Care facility, the client stated that the pain in his legs from the cellulitis was so severe that he could not leave his bed. The client received both medical support and case management at his bedside. After several weeks of assistance from the program, the client stated that he felt less pain in his legs and was able to walk around on his own. During the weekly case management conferences, the team agreed that this client's physical and mental health status had improved enough to be considered for independent living.

However, the client's cellulitis and hypertension was not fully resolved and in February 2010, the client was admitted to Harbor-UCLA Medical Center. The client returned to the Recuperative Care program the next day. With his history of hospitalizations and chronic medical conditions, the client was eligible to be referred to permanent housing through the AHH pilot project. In March 2010, the client was approved for the AHH program.

The client met with the case manager at Homeless Health Care Los Angeles (HHCLA), the agency that provides case management, housing location, and other supportive services to all AHH participants. Within a few days, the client was approved and placed on a waiting list for a Section 8 certificate to move into permanent housing. In late March, Recuperative Care staff determined that the client's health status had significantly improved. The client may be able to be discharged from the Recuperative Care program into his new home as soon as the Section 8 certificate is processed and a suitable apartment can be located for the client. Alternative discharge plans may need to be implemented if the client is discharged before permanent housing can be secured. HHCLA program staff will continue to work with the client after his discharge from the Recuperative Care program.

17) Housing Specialists - DMH

Goal: Assist homeless individuals, families, and transition age youth (TAY) to obtain and maintain permanent housing.

Budget: $923,000 (annually in MHSA Funding)

Table C.12: Housing Specialists Program Specific Measures

	FY 2009-10	FY 2008-09	FY 2007-08
Number of referrals to program	n/a	842	n/a
Number of property owners contacted	776	360 (QTR)	898

Successes: During the third quarter, the Countywide Housing Specialists, funded through the Mental Health Service Act (MHSA), initiated contacts with 349 unduplicated homeless individuals with a mental illness. Based on these contacts, the Housing Specialists provided a variety of housing related services including the following: 66 individuals received assistance with finding permanent housing; 244 individuals were referred to an emergency shelter funded through DMH; 103 were assisted with moving into a transitional housing program; and, 32 received financial assistance with their move-in expenses (security deposits).

Table C.13: Participants and Services
FY 2009-10, through March 31, 2010

	FYs 2008-09 and 2009-10	FY 2007-08
Chronic homeless individuals	79	-
Homeless individuals	1,789	2,343
Homeless families	140	255
Transition age youth	16	142
Demographics not provided for all participants in families		
Female	1,059	*n/a
Male	930	
Transgender	16	
Hispanic	740	
African American	573	
White	468	
Asian/Pacific Islander	56	
Native American	16	
Other	104	
15 and below	11	
16-24	10	
25-49	1,897	
50+	30	
	FY 2009-10	**Cumulative**
Moving assistance	194	336
Eviction prevention	30	35
Housing (emergency)	1,199	2,006
Housing (transitional)	478	781
Housing (permanent)	460	777
Rental subsidy	146	236
Section 8	215	*215
Shelter Plus Care	11	11
Mental health	681	*681
Life skills	327	327
Residential management	633	633

*Information not available for FY 2007-08.

The Department applied through the Emergency Food and Shelter Program (EFSP) funding for a total of $160,000, $80,000 in motel vouchers and $80,000 in food vouchers. On April 2, 2010, DMH was selected for a Phase 28 award of $62,000 by the EFSP in the following categories: other food - $30,000 and hotel vouchers - $32,000. This will serve as a supplement to the existing Countywide Housing Assistance Program funded through MHSA and the Projects for Assistance in Transition from Homelessness (PATH) grant. These resources will be available countywide, providing food and motel resources to DMH clients served in the directly operated clinics in all eight Service Planning Areas.

Challenges: The Department continues to be challenged with assisting our target population to identify affordable permanent housing. DMH relies on rental subsidies provided through contracts with the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA) to access private rental housing. There are still very limited Federal housing subsidies available for DMH clients through Shelter Plus Care and none through the local Homeless Section 8 Programs offered by both HACLA and HACoLA. The Department has been awarded 25 HACoLA and 99 HACLA Shelter Plus Care certificates and is currently waiting for the contract to be executed which is expected to occur in May 2010.

Action Plan: The Countywide Housing Employment and Education Resource Development is planning to hold its Third Annual Housing Specialists Training Institute designed to prepare and/or enhance individuals working as Housing Specialists to effectively perform their jobs of assisting individuals with securing adequate and affordable housing. The Department is currently working to find additional ways to identify other affordable permanent housing to meet the housing needs of the low and very low income population which DMH serves. The Department will continue to apply for rental subsidies offered by the local housing authorities; seek other funding sources for rental subsidies; and disseminate information regarding the availability of affordable housing projects that target individuals with low income. In addition, DMH through (MHSA Housing Program) has committed capital development funds and capitalized operating subsidies for 29 local housing projects thereby creating a pipeline of approximately 728 new affordable housing units in Los Angeles County. One of these projects developed by Skid Row Housing Trust, the Charles Cobb, opened in April 2010, and residents are currently moving into the units. This project has 76 units for individuals who are chronically homeless with a mental illness. Twenty-five of the 76 units are dedicated to MHSA eligible clients.

Client Success Story: A 55-year-old male recently lost his business and apartment. He then started living with friends who asked him to move out after a month. In addition, he had been diagnosed with diabetes and he was not able to continue buying his test strips and insulin. He came to the directly-operated clinic in his area seeking assistance with his current crisis. Through Crisis Resolution Services, the mental health clinic was able to secure an emergency bed through the Temporary Shelter Program. During his stay at the emergency shelter, he was assisted with applying for Section 8 and after several months, he received his Section 8 voucher. In addition, a community-based program was identified that provides him with insulin and test strips free of charge. Currently, the client is in permanent housing and awaiting Social Security Income benefits. Because of MHSA funds, this client is on his way to a better life with greater independence.

18) Just In-Reach Program

Goal: Engage homeless nonviolent inmates upon entry into jail. Develop a release plan that coordinates an assessment and links clients to supportive services, benefits, and housing options upon their release. Case management team works with clients to obtain employment and explore rental subsidy eligibility.
Budget: $1,500,000 (One-Time Funding)

Table C.14 : Just In-Reach Program
FY 2009-10, through March 31, 2010

	Cumulative		Cumulative
Homeless Individuals	250	Housing (emergency)	14
Chronic Homeless	331	Housing (transitional)	150
		Housing (permanent)	89
Female	172	Moving assistance	54
Male	338	Rental subsidy	8
Hispanic	138	Life skills	40
African American	225	General Relief (and Food Stamps)	81
White	178	General Relief only	69
Asian/Pacific Islander	14	Food stamps only	42
Native American	3	SSI/SSDI	30
Other	51	Veterans' benefits	23
(not for all participants)		Case management	456
		Health care	34
16-24	103	Mental health care	30
25-49	526	Substance abuse, outpatient	49
50+	102	Substance abuse, residential	77
		Transportation	129
Job training	464	Legal advocacy	167
Job placement	57		
Education	89		

Program Specific Measures	Cumulative
Number of participants who received intake/enrollment	532
Number of participants who received intake/enrollment within 72 hrs of initial interview	362
Number of participants who did not complete program (exited prior to completing)	130
Number by violent crime	139
Number by non-violent crime	395
Number by area of residence prior to incarceration (most frequent residence)	370
Number by area of residence prior to incarceration (second most frequent residence)	60
Number of times in County jail	682
Number of times in State prison	115
Number of participants with a service plan	1,982
Number of participants with a service plan within a week from intake/enrollment	1,954
Number of referrals provided to participants by type:	
- Service(s): Case management, health/medical care, mental health, substance abuse treatment, transportation, and mentoring	347
- Benefit(s): CalWORKs, General Relief, Food Stamps only, Section 8 and/or Shelter Plus Care, SSI/SSDI, Medi-Cal, Veterans	206
- Job/education related service(s): Job training, employment referrals, education	544
Number of participants who do not return to jail	405
Emergency Housing/Case Management	**Quarter**
Average stay at emergency/transitional housing: (11 participants)	98 days
Case management (level 2)	
Average case management hours for each participant per month:	3 hours
Total case management hours for all participants during current reporting period:	1,404 hours
Number of cases per case manager:	36 cases
Longer-term Outcomes (6 or more months) FY 2009-10, Third Quarter	
Maintained permanent housing	50
Obtained employment	8
Maintained employment	8
Enrolled in educational program, school	10
Case management	153

Successes: Clients had a recidivism rate that averages about 34% through the first 21 months of the program. Compared to the County jail population's recidivism rate of 53% during a similar time frame, this is significantly lower. The program has been measured with similar, more established models in Chicago, New York and Washington, DC and measures up positively. The Just In-Reach program (JIR) has assisted in placing 199 homeless or chronically homeless inmates into transitional or permanent housing during the program year. With partnerships with other agencies, the JIR program has contributed directly toward move-in costs for permanent housing. After housing placement, staff continues to work with clients to provide them the necessary supportive services to continue their success.

Challenges: The housing staff encounters significant challenges such as limited units and overbearing requirements. The disqualifications for public-assisted housing occur all too often which guides staff toward private landlords. The biggest barrier with the private landlords is the credit check. JIR employment specialists have had difficulty placing clients into jobs. Most of JIR clients report not having any history of employment. Coupled with the current state of the job market, JIR staff relies heavily on existing and new employer relationships to place the clients. Clients are also given incentives such as clothing and transportation passes for their job search. Once the client is placed, intensive follow up continues with the client to aid them in adapting to new circumstances.

Action Plan: JIR established a Landlord Advisory Board in an effort to create more housing opportunities for clients being released from jail. Private property owners and public housing providers are brought together in regular meetings for informative sessions that have been able to ease concerns to landlords about the population JIR serves. Current landlords of JIR clients voiced their positive opinions on how the program is able to support individuals to live independently. The Sheriff's Department participates in these meetings. Moreover, JIR increased incentive plans for participants by offering transportation and store credits for simply returning for a case management session post release. As a result, this has expanded to job search and housing placements.

Client Success Story: Client M, a 47-year-old Hispanic of Puerto Rican descent, used drugs and had been in and out of County jail and prison since the age of 16. Last arrested in June 2008, he completed the Merit program at South Facility (Pitchess Detention Center) and was court ordered to Tarzana Treatment Centers for one year, which he completed last February. Currently, the client has been residing at Tarzana's Transitional Housing program in Reseda. He has secured full-time permanent employment at Micro 2000 and is currently in the process of securing his own private apartment. JIR has approved the move-in costs and lease so the client can move into his own apartment by May 1st. He has remained focused throughout this whole process and has not lost sight of the importance of his sobriety by maintaining his support network, Alcoholics Anonymous (AA) meetings, individual counseling, etc. The client's schedule consists of a daily routine which begins at 3:30 a.m. so that he can commute by bus to be at work at 6:00 a.m. He attends meetings/groups from 5:00 p.m. to 9:00 p.m., and his curfew is at 10:00 p.m. This client has been able to stay focused on his goals with the help of JIR support services.

19) Long Beach Housing Now – PATH Ventures
Budget: $300,069 (Board Approved Funding)

Table C.15 : Long Beach Services for Homeless Individuals
FY 2009-10, through March 31, 2010

	Cumulative		Cumulative
Chronic Homeless	2	Moving assistance	2
Female	1	Housing (transitional)	2
Male	1		
		Case management	2
African American	1	Social/community activity	2
White	1	Transportation	2
25-49	1	Food	1
50+	1	Utility assistance	1

Successes: PATH Ventures successfully negotiated a lease agreement with a market rate landlord to house two chronically homeless individuals. Staff coordinated with local churches to provide furniture donations and delivery, found move in assistance money and grocery gift cards for the new tenants. The program has commitments from the church community and partners to provide these same services to all of the tenants moved into housing.

Challenges: When starting up a scattered site leasing program, convincing landlords to work with the program is challenging. Program staff continues intensive marketing to sell the program and convince the landlord or owner that they would benefit from working with the team.

Action Plan:
- Apply for SSI benefits or increase income through employment
- Connect the clients with medical/mental health providers
- Increase skills through training or education
- Work with clients on life skills required for independent living (budgeting, money management, housekeeping, and other tenant responsibilities)

Client Success Story: Since the program just started, staff does not have a dramatic success story, but a small success that is hoped will eventually lead to a great success story. The clients that were moved into housing had been homeless for five years. The City of Long Beach outreach workers have been working with these clients to try to get them off the streets and into shelter. It was difficult to get the clients to agree to participate in the scattered site program because of barriers including poverty, mental health issues, and general disbelief that they would actually get housing. As of this quarterly report, they have maintained their housing for almost four months without any major problems. Additionally, through word of mouth, these clients have convinced others on the street that housing is a viable option and many who refused to participate initially reached out to the program.

20) Long Beach Services for Homeless Veterans

Goal: Assist veterans with housing, employment, SSI/SSDI, and legal issues such as child support. The program provides case management, outreach, and mental health services.
Budget: $500,000 (Ongoing Funding)

Table C.16 : Long Beach Services for Homeless Veterans
FY 2009-10, through March 31, 2010

	Cumulative		Cumulative
Homeless Individuals	1,500	Education	10
Chronic Homeless	196	Job placement	9
Homeless Families	19	Job training	10
Female	175	General Relief (and Food Stamps)	23
Male	1,539	General Relief	6
Transgender	1	SSI/SSDI	7
Hispanic	273	Section 8	1
African American	663		
White	613	Veterans' benefits	48
Asian/Pacific Islander	39	Case management	270
Native American	8	Health care	7
Other	119	Mental health	64
16-24	70	Substance abuse (outpatient)	3
25-49	817	Substance abuse (residential)	10
50+	828	Transportation	349
		Life skills	76
Eviction prevention	5	Social/community event	20
Moving assistance	40	Other	
Housing (emergency)	172	Credit repaired	58
Housing (transitional)	61	Legal services	11
Housing (permanent)	53	Driver license reinstated	35
Rental subsidy	16		

Program Specific Measures	Cumulative
Number of mental health coordination activities conducted	66
Number of mental health assessments provided to homeless veterans by MHALA	30
Number of meals provided to homeless veterans. (includes food/meal vouchers)	141
Number of homeless veterans whose child support payment was eliminated or reduced by SPUNK	68
Number of outreach sessions conducted by U.S. Vets and DHHS	37
Number of homeless veterans contacted through outreach sessions by U.S. Vets and DHHS	1,073
Number of outreach sessions conducted with veterans recently returning from tour of duty	5
Number of mental health educational pamphlets developed	4

Successes: The Long Beach Homeless Veterans Initiative (HVI) is a collaborative effort among four partner agencies – City of Long Beach, Department of Health and Human Services (Long Beach Health Department); Mental Health America of Los Angeles (MHALA); Single Parent United 'N' Kids (SPUNK); and United States Veterans Initiative (US VETS) – to help end homelessness among the men and women who have served in the United States Military. To help the clients achieve housing stability, the HVI partners provide a range of services, including: outreach and engagement, case management and other supportive services, and housing linkages. In addition, the HVI partners collaborate with other agencies and programs to leverage resources.

MHALA, US VETS, and the Long Beach Health Department continue to coordinate outreach and engagement activities to homeless veterans. Since the beginning of HVI, agencies have contacted homeless veterans through such activities. MHALA initiated street outreach by the Nurse Practitioner to facilitate mental health evaluations.

HVI clients received a variety of supportive services, such as case management, benefits coordination, mental health services, transportation, and assistance with child support cases. These services are vital in overcoming barriers to self-sufficiency and housing stability. At the MHALA Homeless Assistance Program (HAP) Drop-In Center, the newly established Veteran's Coordinator continues to expedite connections to mental health and veterans' services. Additionally, this quarter SPUNK closed ten child

support cases for a total arrears savings of $341,508. As a result of child support cases being closed or reduced, the HVI clients often experience an improvement in credit rating and/or a reinstatement of driver's licenses.

HVI partners are leveraging resources funded by the local Continuums of Care and other sources to provide housing. The Veterans Reentry Project, operated by US VETS, expanded to serve 23 recently separated veterans. This expansion allows US VETS and the other HVI partners to increase services to the veterans who have served in the Iraq and Afghanistan conflicts. HVI staff members also utilize the Department of Housing and Urban Development and the Department of Veterans Affairs Supported Housing (HUD-VASH) Program and the Homelessness Prevention and Rapid Re-Housing Program (HPRP) to expedite permanent housing placements.

Collaborations with other agencies and programs are a vital component of HVI success. Key community partners include: the Veterans Affairs (VA) Long Beach Healthcare System, Housing Authority of the City of Long Beach, and the Long Beach Connections Initiative. During July 2009, the Long Beach Connections Initiative conducted the Long Beach Homeless Survey to examine service needs in the targeted area and to help design effective solutions to homelessness. Of the 345 homeless individuals identified during the survey, 74 were veterans. By leveraging funding, including HVI, 10 veterans have been permanently housed, and one veteran is in substance abuse treatment. HVI staff members also regularly collaborate with VA Long Beach Healthcare System personnel to connect clients to medical services, mental health services, and the HUD-VASH program. As part of this collaboration, staff members from US VETS, MHALA and the VA Long Beach Healthcare System will participate in the upcoming Healthy Mind/Healthy Body event, which is being coordinated by the Long Beach Health Department. This annual mental health resource event will be held at Recreation Park on May 22, 2010.

Challenges: The HVI partners continue to work with the Long Beach VA Healthcare System to strengthen outreach and services for homeless veterans being discharged from VA inpatient programs. The VA Hospital has experienced delays with implementing the HUD-VASH placements due to staff shortages and high demand for affordable housing resources.

Action Plan·

- Outreach to Long Beach VA Healthcare System Inpatient Case Management personnel to increase collaborative efforts in working with homeless veterans recently discharged from inpatient treatment.
- Meet with staff from the Long Beach VA Healthcare System and Housing Authority of the City of Long Beach to strengthen coordination of the HUD-VASH resources for HVI clients.

Client Success Stories: Through HVI-coordinated outreach efforts, US VETS enrolled a decorated veteran, who served in Vietnam, Gulf War, and Operation Iraqi Freedom into the Veterans Reentry Project. The client was connected to the Long Beach VA Healthcare System for veteran benefits, medical and mental health services, and a HUD-VASH voucher to sustain stable permanent housing.

Client is a disabled US Army veteran who had been living in his van with his dog for the last ten years. The veteran-specific outreach staff at the Long Beach Multi-Service Center placed the client to a pet-friendly housing unit. MHALA provided outreach, case management services, and mental health interventions to a client who had a history of substance abuse and multiple mental and physical health issues, and who had been living on the streets for three years. The client is now living independently and working towards full-time employment.

21) Los Angeles County Homeless Court Program

Goal: Assist homeless individuals with clearing outstanding tickets, fines, and warrants upon successful completion of rehabilitation recovery programs for mental health, substance abuse and/or other issues.
Budget: $379,000 (On-going Funding)

Table C.17: Los Angeles County Homeless Court Program Participants
FY 2009-10, through March 31, 2010

	FY	Cumulative		FY	Cumulative
Homeless Individuals	731	1,919	Hispanic	180	461
			African American	358	976
Female	258	660	White	149	380
Male	472	1,255	Asian/Pacific Islander	21	36
Transgender	1	4	Native American	9	15
			Other	14	51
Alternative court	650	1,816			
Transportation	74	91	15 and below	-	-
Food card	204	204	16-24	82	178
Housing (emergency)	36	36	25-49	457	1,225
Substance abuse treatment (residential)	2	2	50+	192	516

Program Specific Measures	FY	Cumulative
Number of Los Angeles County Homeless Court motions received	2,094	5,483
Number of program participants whose qualifying motions are submitted to and filed by Superior Court, and resolved within 30 days of submission	2,046 98%	5,453 99%
Number of audited records in the Superior Court's automated case management systems (TCIS/ETRS) that are accurate	119 98%	266
Number of motions that are granted by Superior Court	2,005 96%	5,330
Number of motions that are denied by Superior Court	-	8
Number of individual cases filed under the Los Angeles County Homeless Court	2,114	6,007
Number of participants whose applications are submitted to the Los Angeles County Homeless Court within 30-days of initial contact with participant	623	1,738
Number of participants that have Los Angeles County citations or warrants dismissed upon program completion	682	1,804
Number of participants who complete at least 90 days of necessary case management, rehabilitative, employment or mental health services before their first appearance in Court	650	1,810
Number of case managers who receive training on Los Angeles County Homeless Court benefits, application and eligibility requirements, and legal resources	531	1,496

Successes: The number of applications to the Homeless Court Program increased by approximately 35% during this quarter, demonstrating both the growing need for Homeless Court services in the community and the excellent work done by the Homeless Court team in marketing the program through case managers. One of Public Counsel's strategies for handling the higher volume of applications has been to improve the Homeless Court client management database. This has resulted in the automation of some of the essential steps within the Homeless Court process, which has improved both efficiency and accuracy. Public Counsel also hired an additional part-time administrative assistant to help with the day-to-day operations of the Homeless Court Program.

In addition to the rise in application numbers, there has been an increase in attendance at Homeless Court sessions during the quarter. Of particular note was one of the March sessions, held for the first time at the Watts Labor Community Action Committee ("WLCAC"). The facilities at WLCAC were excellent for hosting a Homeless Court session and a record number of clients attended. The Homeless Court team was also able to use this opportunity to outreach to new community partners. Finally, the Informal Juvenile and Traffic Court has agreed informally to resolve citations for Homeless Court clients who received certain eligible citations as minors. An initial group of eight clients had citations resolved as part of a pilot program and Public Counsel is working with Juvenile Court staff to fine tune the resolution

process. Public Counsel hopes that the pilot program can continue despite staff cuts the Court has had to accommodate over recent months.

Superior Court continues to work with Public Council during their staffing transitions to help ensure a smooth continuation of the program. This includes refining existing communication protocols to help maintain one point of contact to inquire/resolve issues that periodically arise in a timely manner.

Challenges: The record number of applications to the Homeless Court Program represents a challenge as well as a success because the high volume of applications has resulted in delays in processing. In addition, there continue to be delays in receiving resolution of citations from the jurisdictions of Inglewood and Pasadena.

Another challenge for the Homeless Court team is the shortage of space within the City Attorney's Office where the program is administered. The current staff of four (two full-time and one part-time administrative staff members plus the staff attorney) is accommodated in an office measuring 9' x 13'. While Public Counsel is very grateful to the City Attorney's Office for the space and the necessary access to criminal record databases used to assess clients' eligibility, the tight space has limited the program's ability to employ more volunteers to help with the volume of applications. Moreover, although Public Counsel has explored the possibility of conducting Homeless Court work at the Public Counsel office, the majority of work cannot be done outside the City Attorney's Office because of the confidential criminal record information contained in client files.

In response to funding shortfalls, Superior Court commenced a business plan that includes staff reductions over the next 18 months to meet specific budget goals. Several of the court staff assigned to the Los Angeles County Homeless Court Program were curtailed, and newly assigned staff have taken over those responsibilities. Superior Court continues to experience difficulties in receiving court records from all court locations in a timely manner. While this represents a small percentage of motions received, it requires extra work to monitor the status of requests.

Action Plan: Public Counsel is optimistic that the hiring of a new part-time administrative assistant and more aggressive recruiting of volunteers will help in responding to the high volume of incoming applications. The Homeless Court team is working with the City Attorney's Office to try to increase the workspace/terminals available for use by additional staff and volunteers. The Homeless Court team also continues to train and update case managers about the program's criteria to ensure that submitted applications fulfill basic requirements, thereby reducing the number of ineligible applications.

Public Counsel is meeting regularly with the City Attorney's Office to identify any weaknesses in the current Homeless Court process, to make modifications as necessary, and to ensure that both Public Counsel and the City Attorney's Office are aware of key issues or changes that need to be made. Finally, while there has been some improvement in the resolution of citations in Torrance, the Homeless Court team continues to work closely with the Public Defender's Office to replicate this success in Inglewood and Pasadena.

Superior Court is undergoing internal cross training with newly assigned staff for this program to ensure a smooth continuation of the workflow.

Client Success Story: Client X completed a residential substance abuse treatment program and had his citations resolved through Homeless Court. He is now living in permanent housing and is employed as a full-time mentor for the HIV support group where he received services. In addition, Client X volunteers at a community Lesbian/Gay/Bisexual/Transgender (LGBT) center.

Client Y completed a residential substance abuse treatment program and had 17 citations resolved through Homeless Court. He has since married, moved into an apartment, completed a certificate in drug and alcohol counseling, and enrolled at a local university.

22) Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program

Goal: Assist individuals to move into permanent housing.
Budget: $1.1 million (One-Time Funding)

Table C.18: Moving Assistance for Single Adults Program Measures
FY 2009-10, through March 31, 2010

(unduplicated count)	FY	Cumulative
Homeless Individuals	658	1,425
Number applications received	656	1,423
Moving assistance approved	181	371
Percent applications approved	28%	29%
Average days to approve	17	*
Average amount of grant	$604	**
***		
General Relief (w/FS)	320	482
General Relief only	41	41
Food Stamps only	53	62
Medi-Cal/Medicare	-	1
SSI/SSDI	44	64
Section 8	3	4
Shelter Plus Care	2	12
Veterans' benefits	77	77

	Cumulative
Female	413
Male	666
16-24	57
25-49	518
50+	504
Hispanic	150
African American	677
White	216
Asian/Pacific Islander	2
Native American	27
Other	7
Demographic information was not available for all clients during FY 2007-08.	

* FY 2007-08 average was 20 days; FY 2008-09 average was 12 days.
**FY 2007-08 average was $575; FY 2008-09 average was $722.
***Cumulative data for benefit information only includes FYs 2008-09 and 2009-10.

Successes: The program maintained a steady increase in the number of referrals for this reporting quarter.

Challenges: To date, the program is still experiencing a low number of approvals despite the increase in referrals.

Action Plan: This program will sunset on June 30, 2010. Program management is preparing to notify community partners and DPSS staff.

Client Success Story: Mr. G, a homeless participant, had difficulty in getting a job because of his situation. Fortunately, Mr. G was referred to the Single Adults Move-In Program and was provided the security deposit to move into permanent housing. The move enabled Mr. G to search and apply for employment. He called his HPI Eligibility Worker to inform him that he has gone for several interviews and may be offered a permanent job soon.

23) Project 50

Goal: To move 50 of the most vulnerable, chronically homeless individuals off of Skid Row and into permanent housing.
Budget: $3.6 million (Board Approved Funding)

Table C.19: Project 50 Participants and Services
FY 2009-10, through March 31, 2010

(unduplicated count)	Cumulative		Cumulative
Chronic Homeless Individuals (ever housed)	67	Education	2
		Job training/referrals	2
		Job placement	2
Female	13		
Male	53	General Relief (GR,FS)	15
Transgender	1	General Relief only	9
		Food Stamps	-
Hispanic	7	Medi-Cal/Medicare	46
African American	51	Section 8	3
White	9	Shelter Plus Care	46
Asian/Pacific Islander	-	SSI/SSDI	46
Native American	-	Veterans	15
Other	-		
		Case management	64
25-49	25	Health care/medical	64
50+	42	Mental health/counseling	64
		Social/community activity	38
Eviction prevention	15	Substance abuse (outpatient)	20
Housing (emergency/transitional)	48	Substance abuse (residential)	14
Housing (permanent)	67	Transportation	45
Rental subsidy	67	Legal Services	11
Moving assistance	2		

Longer-term outcomes (at 18 months)	**Quarter**
Continuing to live in housing	53
Enrolled in educational program	1
Case management	41
Health care	41
Good or improved health	30
Mental health/counseling	40
Good or improved mental health	30
Substance abuse treatment (outpatient)	27
Substance abuse treatment (residential)	2
No drug use	38
Reunited with family	3

Case management	**Quarter**
Level 3 case management services	
Average for each participant per month:	4 hours
Total hours for all participants:	416 hours
Number of cases per case manager:	20 cases

Successes:
Housing retention rates:

- At 6 months: 37 total housed; 33 remained housed (or alt housed) – 89.2% retention rate
- At 12 months: 49 total housed; 42 remained housed (or alt housed) – 85.7% retention rate
- At 18 months: 59 total housed; 51 remained housed (or alt housed) – 86.4% retention rate
- At 24 months: 67 total housed; 54 remained housed (or alt housed) – 88.5% retention rate (6 participants passed away; all of whom were either housed or alternatively housed at time of passing)

Program Specific Measures	FY	Cumulative
Number of participants who exited housing	-	8
Number of participants developing individualized treatment plans	5	64
Number of participants participating in a housing retention group	-	41
Number of Project 50 participants having arrests	-	21
Number of Project 50 participants having hospitalizations	1	19
Number of Project 50 participants having an emergency room (ER) visit	-	12
Number of Project 50 participants with increased income (i.e., due to SSI/SSDI, GR)	-	28

Project 50 has an 89% housing retention rate. Project 50 participants and staff are preparing to move into the newly constructed Charles Cobb Apartments in April 2010. The Charles Cobb Apartments will allow the Integrated Supportive Services Team to provide intensive services on-site in one location. Each unit in the Charles Cobb Apartments will offer its resident a private bathroom and kitchen, further enhancing recovery and community re-integration for the participants.

The goal for the project is for homeless participants to be sustained in permanent supportive housing. The project has also demonstrated that various County, City and non-profit agencies can work together as a team to make this project a success. As part of Project 50's continuing Community Re-integration efforts, participants have participated in community events, such as fishing trips to local beaches and visits to local museums. Participants are also actively seeking out and participating in other community-based events.

Challenges: Working as a team, the Project 50 staff has had significant success in maintaining housing for the chronic homeless. The team continues to work with clients to resolve substance abuse, poor money management, and rental payment issues. A few Project 50 participants have passed away, during this time period, as a result of pre-existing medical conditions. Project 50 was able to reconnect one participant, who had terminal cancer, with his family prior to his passing. All Project 50 participants who passed away were remembered during special remembrance/memorial services.

Action Plan:

- Encourage staff stability, explore development of a process group for participants to deal with loss;
- Continue to add participants to continually have 50 clients currently housed and coordinate completion of all necessary documentation for an additional 24 participants; and
- Coordinate the anticipated move of participants and staff to the Charles Cobb Apartments in April 2010.

Client Success Story: One participant, who was formerly employed with the Merchant Marines prior to becoming homeless, successfully completed training requirements and passed both parts of the licensing exam to become eligible to be reemployed with the Merchant Marines. Project 50 is working with this participant to obtain security clearance so that he may begin full-time work.

24) Santa Monica Homeless Community Court

Goal: Assist homeless individuals with clearing outstanding citations, warrants, and misdemeanor offenses upon successful completion of mental health, substance abuse and case management.

Budget: $540,000 (Board Approved Funding); $31,000 for transitional housing

Table C.20: Santa Monica Homeless Community Court Participants and Services
FY 2008-09, Cumulative (February 2007 – June 2009)

(unduplicated count)	**Cumulative**		***Cumulative**
Chronic Homeless Individuals	155	15 and below	-
		25-54**	121
Female	49	55+	34
Male	106	Housing (emer/trans)	66
		Housing (permanent)	26
Hispanic*	17	Rental subsidy	11
African American	34		
White	102	Alternative court	155
Asian/Pacific Islander	3	Case management (level 3)	148
Native American	1	Mental health	65
Other	15	Substance abuse (outpatient)	5
		Substance abuse (residential)	32

Program Specific Measures	**Cumulative**
Total number of clients who have enrolled in Program	155
Number who participate that have citations or warrants dismissed upon completion	118 (76%)
Number who receive an emergency shelter bed and remain for two weeks or longer	35 (53%)
Number who accessed psychiatric and/or mental health services, received their mental health services at a DMH facility within the six-month program period (February-June 2009)	24 (37%)
Number who enter residential treatment complete a substance abuse program of 90 days or longer	24 (71%)
Number of arrests for all Court participants that have been placed in an emergency, therapeutic, transitional or permanent bed (or some combination of bed-types) for 90-days or longer as compared to the 90 days prior to entering residential program	70% reduction
Number of permanently housed who continue to be housed after four months, or will still be housed at the end of the program periods (which may be less then four months after housing placement)	24 (92%)
Average length of stay in emergency housing:	14-160 days

*Latino is not categorized as a distinct race by Santa Monica Homeless Community Court.
** Age range is categorized differently by Santa Monica Homeless Community Court.

Successes: The most successful ongoing collaboration which the Homeless Community Court program is engaged in is its relationship with Edelman Mental Health Center. Every Thursday morning, the Edelman psychiatrist and social worker, provide in-office services at the St. Joseph Center Homeless Services Center and occasional outreach to Homeless Community Court clients. The primary benefit of this Edelman collaboration is giving clients easy access to psychiatric care, with medications administered at two area pharmacies. Given the limited mobility, organization and/or motivation of many Court clients, this is often a superior service option to conventional mental health clinics. Integrating these psychiatric services into the pre-existing relationship which clients have with their program Case Manager and Mental Health Specialist also provides context which can help overcome service barriers stemming directly from mental health symptoms. A secondary but lasting benefit of the Edelman collaboration is streamlining the eventual transfer of client services from in-office services at the Homeless Services Center to long-term mental health care at Edelman or other DMH facilities.

Exodus Full Service Partnership (FSP) has been another valuable collaborator with the Homeless Community Court Program. A dually diagnosed client referred to this program was rapidly entered into intensive services with an outreach case manager. Working in tandem with Homeless Community Court and Exodus staff, this client was able to access a full range of services including psychiatric care,

substance abuse treatment, emergency shelter, and permanent housing at a sober living. The FSP's collaboration with Exodus Mental Health Urgent Care Center accelerated the client's access to mental health services and dealt with acute mental health situations. This collaboration has also contributed to St. Joseph Center's familiarity with the services offered by Exodus Urgent Care, benefiting the agency more generally. Building on the success of the Chronic Homeless Program (CHP), the program has managed to link many CHP participants to the Court which has resulted in the removal of barriers and has allowed for the successful transition by clients to the next phase of their lives. Continued collaboration between service providers, police and fire has allowed the program to continue engaging clients in the field and seizing opportunities to refer them to the program, when it appears they will be receptive to services. The program's talented Public Defender is greatly appreciated not only by the Resource Coordinator but also by the service providers. She creatively strikes a balance between advocating for her clients and using her motivational interviewing techniques to help clients see the benefits of connecting to services.

Challenges: The voluntary nature of the program allows many of the most chronic, high users of police, fire and social services the opportunity to opt out of the program. These are the very people the program had wished to engage in services using the authority of the Court. Experience has shown that many of the most chronic homeless do not want to access services. Moreover, the voluntary nature of the program does not allow the program to use the authority of the Court to connect individuals to much needed resources, including: mental health, psychiatric, medical, substance abuse and monetary assistance programs – all of which can be barriers to stabilizing clients, housing them and helping them maintain their housing.

Action Plan: The Court will only accept participants cited with quality of life crimes – misdemeanors and infractions. The Court will not accept felons or sex offenders. The very nature of the crimes, misdemeanors and infractions, prevent the court from following participants for extended periods of time and result in citations being dismissed with limited client progress. Greater oversight by the Court could have a very positive influence on participants and result in better outcomes. Currently, participants average 2-3 court visits before their citations and warrants are dismissed. This impacts both substance abuse treatment and housing placements. Indeed, because of Case Management initiated by the Court, some individuals may achieve outcomes months after their exit from the program.

Court participants would benefit from a more directive tone and more exact prescriptions from the Court. While this has improved, the program continues to need progress in this area. The court appointed psychiatrist linked with the program supports this change in tone of court orders, and feels that it would result in greater client success. Furthermore, it would lend more objective finality to the process, taking out a great deal of ambiguity for the client.

Table C.21: Santa Monica Homeless Community Court (transitional housing and services)
FY 2009-10, Third Quarter

Homeless Individuals	6	Housing (transitional)	6
Male	6	Job training	6
White	5	Job placement	2
Hispanic	1	Veteran benefits	2
24-49	3	Substance abuse treatment (residential)	6
50+	2		

Successes: Eventually, one participant moved into his own apartment. Two participants who completed the CLARE Foundation's program received employment.

Challenges: It has been challenging for participants to stay in the program.

Action Plan: Staff continues to reinforce the benefits of staying in the program.

25) Santa Monica Service Registry

A) Step Up on Second
Budget: $ 518,000 (Board Approved – Third District)

Table C.22: Step Up on Second, Santa Monica Service Registry
FY 2009-10, through March 31, 2010

(unduplicated clients)	Cumulative		Cumulative
Chronic Homeless Individuals	27	Moving assistance	18
		Housing (transitional), 38 day stay	16
Female	9	Housing (permanent)	15
Male	18	Housing (emergency)	4
		Eviction prevention	5
Hispanic	5	Rental subsidy	18
African American	5	Legal	4
White	15	General Relief with Food Stamps	1
Asian/Pacific Islander	2	Medi-Cal/Medicare	2
		Case management	26
25-49	13	Health care	6
50+	14	Life skills	26
		Mental health care	26
		Social/community activity	26
Job training	1	Transportation	26
Section 8	2	Substance abuse treatment (outpatient)	3
Shelter Plus Care	6	Substance abuse treatment (residential)	4
Supportive Housing Program (SHP) subsidy	1	SSI/SSDI	1
Education	1	Alternative court	2
Case management level 3			**Quarter**
Average hours per case:			20
Total number of hours:			454
Caseload per case manager:			6
Longer-term outcomes (six or more months)			
Continuing to live in housing			6
Continuing to receive rental subsidy			6
Case management			7
Health care			5
Good or improved physical health			5
Mental health care			5
Good or improved mental health			5
No drug use			4

Successes: The Step Up team has continued to provide case management services to 22 active clients. During this quarter the team assisted one member with increasing her income from GR to Social Security benefits. Two clients have received their Section 8 vouchers, and the team actively searched for housing with these clients. Two other clients are waiting for the next Santa Monica Housing Authority voucher issuance session to receive their vouchers. One client has moved into housing, twelve are still permanently housed in their own apartments, and three are in transitional housing. Staff assisted one client with navigating the court system, allowing him to be released to the community in favor of treatment. The team enrolled two individuals into money management services at Step Up.

Challenges: The symptoms of several clients' mental illnesses (treated and untreated) are a challenge as they cause the clients to mistrust and resist the Step Up Home Team. Particular challenges include: paperwork, appointments, the Housing Authority, building managers, members of the public, fellow tenants, money management and medical care. Along with finding housing, Step Up must help clients maintain and retain their housing. Several clients are substance abusers, and two of our clients are physically ill because of their past and present abuse of drugs and alcohol. It is not uncommon for several clients to receive lifestyle tickets from the police. For example, one client committed a crime because of his mental illness that could have serious repercussions for him. Staff are assisting him with his legal issues.

Action Plan:
Program staff will continue to:

- Obtain Section 8 vouchers for remaining clients;
- Encourage clients to enroll into money management or to work on establishing and maintaining a budget, which will enable them to become self sufficient to obtain and retain housing;
- Advocate and guide clients through the legal system to clear up legal issues;
- Provide support and transportation to and from medical appointments and other services when needed;
- Locate and educate apartment managers about the benefits of the Section 8 program and encourage them to work with the City of Santa Monica Housing Authority;
- Build strong relationships with property managers that have accepted Section 8 and our clients; and
- Provide education and support to clients on how to maintain and retain housing, daily life skills and to locate resources in the community.

Client Success Story: Client B is 63 years old and has been homeless on the streets of Santa Monica for six years. The HOME Team first made contact with her in November 2008. She informed the team that she was a Step Up member and had not utilized services in years. She was initially very open to return for services, but unwilling to follow through in lots of areas. The Step Up HOME Team discovered she had received a Santa Monica Section 8 voucher in the past and allowed it to expire and remained homeless. She has been using the voice mail and mail service at Chrysalis and receiving GR and food stamp benefits from DPSS. She was also receiving medication and counseling from Venice Family Clinic. On numerous occasions she had been in contact with the Santa Monica Police Department (SMPD) for trespassing while sleeping on private and public property. For a short time in 2009, she was sleeping inside at Daybreak Shelter after receiving a referral from the SMPD Homeless Liaison Team during one of her many contacts. She was unable to sleep in the shelter's dorm-type setting and returned to the streets. Step Up HOME Team offered her a referral to SAMOSHEL emergency shelter and she refused. Step Up continued to have outreach contact with the client for several months.

In July 2009 she stated she was ready to be housed. Step Up's Team completed Section 8 paperwork and requested supporting documents. Client B had difficulty in gathering the required paperwork and required assistance in completing this task. She had another contact with SMPD and failed to appear in court on citation. Step Up encouraged her to return to court and offered assistance in navigating this process. When she wanted to return to Texas after her case was cleared because her life was a mess, Step Up encouraged her to just follow through on her application for housing and she agreed. Step Up submitted her completed housing paperwork in August 2009, the client was approved for a voucher in November, ands she moved into her own apartment in December of that year. Client B finally agreed to allow the Step Up HOME Team to accompany her to the Social Security Administration (SSA) office to research the benefits for which she qualifies. While at the SSA office, she was informed that she was eligible for retirement and survivor benefits. The client is now housed in a fully furnished, subsidized apartment, and she is receiving in excess of $900 a month in mainstream benefits and is able to sleep in peace.

B) OPCC Safety Net (Access Center)
Budget: $ 660,000 (Board Approved, Third District)

Table C.23: OPCC Safety Net (Access Center)
FY 2009-10, through March 31, 2010

(unduplicated clients)	Cumulative		Cumulative
Chronic Homeless	47	Section 8	10
		SSI/SSDI	8
Female	13	Shelter Plus Care	8
Male	34	Job placement	1
		Job training	4
Hispanic	3		
African American	10	General Relief with Food Stamps	3
White	32	General Relief	2
Asian/Pacific Islander	1	Food Stamps	2
Native American	-	Alternative court	4
Other	1	Case management	44
		Health care	17
25-49	20	Mental health care	28
50+	27	Substance abuse treatment (residential)	6
		Substance abuse treatment (outpatient)	8
Housing (emergency)	33	Food	19
Housing (transitional), avg. stay 20 days	8	Clothing	5
Housing (permanent)	17	Transportation	24
Rental subsidy	12	Life skills	13
Moving assistance	13	Recuperative care	1
		Case management level 3	
		Average hours per case:	255
		Total number of hours:	766
		Caseload per case manager:	10
Longer-term outcomes (six or more months)			
Continuing to live in housing			9
Receiving rental subsidy			6
Case management			30
Health care			10
Good or improved physical health			6
Mental health care			11
Good or improved mental health			8
No drug use			0
Number of organizations/agencies that your program has a formal collaboration for this project			3
Number of times collaborative partners met each month			1
Total amount ($) of HPI funding leveraged for project			-
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)			-
Number of participants who have enrolled (entered) into program during the reporting period			2
Number of participants who left the program during this period			-
Total number currently enrolled in program			39
Number of clients who received an assessment (if applicable)			2
Cost per participant			$4,497
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter			n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter			n/a

Successes: OPCC Project Safety Net continues to provide comprehensive wraparound services to 40 of the most vulnerable, chronically homeless individuals on the Santa Monica Service Registry. Currently, 21 individuals are safely off the streets residing in temporary or permanent housing. All 17 participants (100%) who have secured permanent housing remain housed to date. Among the 40 OPCC Project Safety Net clients, 17 individuals are permanently housed, two are in transitional programs, two are in alcohol and substance abuse programs, including one of the most resistant to housing due to mental illness, is now residing in OPCC Safe Haven and taking medication. In addition, four clients are in emergency housing (one in emergency shelter, three in motels). Two of the clients in motels have

secured apartments and are awaiting move-in. With intensive support from Project Safety Net staff, all participating clients who are housed continue to thrive and rebuild their lives in stable housing.

OPCC Project Safety Net began the quarter with a new psychiatrist who has enabled increased flexibility and responsiveness to the special needs and challenges of the clients. The psychiatrist outreaches in the street as well as meeting clients in the program office, and this has facilitated significant success with several individuals struggling with mental health challenges. The psychiatrist has started medication therapy with some of these clients, and has begun to establish trusting relationships with others. These are important first steps for the most challenging clients prior to considering housing.

Discreet and creative collaboration with the Santa Monica Police Department (SMPD) Homeless Liaison Program Team has been effective in moving some of the most fearful clients forward, such as when the police assisted staff in reassuring a severely mentally ill woman that the authorities had made the Safe Haven shelter "safe enough" for her to move into.

Challenges: The remaining clients on the street are some of the most challenging individuals, who due to mental illness, addiction, or extreme alienation, are the most reluctant to interact with, or consider housing options. While progress has been made in developing trusting relationships with the clinician and psychiatrist, the difficulties in conducting medication management on the street are ongoing challenges. Other challenges include clients' frustration with the VA and the long and unresponsive appeals process in obtaining Social Security disability benefits. Supporting housed clients with intensive special needs who require ongoing life skills training continues to be a challenge.

Action Plan:

- Continue to pursue intensive street outreach with the team psychiatrist and include engagement and assessment of clients who have remained reluctant to move into housing due to mental health issues and development of initial medication plans;
- Develop additional supports to housed clients through a housing support group;
- Continue to foster good working relationship with the SMPD Homeless Liaison Program as well as the Santa Monica Housing Authority; and
- Actively recruit local landlords, establish additional housing resources, and continue to develop and strengthen collaborations with other providers in the service network.

Client Success Story: Client P left Florida to come to California in August 2006 to care for her ailing and severely mentally ill mother. However, after a week, their volatile relationship led to the client being forced to live on the streets. Without a support system or services for her addiction or mental illness, Client P became increasingly frustrated, bitter and angry on the street, and felt that no one could help her. As time progressed, her drinking and drug use increased as a way of self-medication. When OPCC Project Safety Net began working with her in December 2008, she was extremely angry and distrustful. She drank heavily and used methamphetamines. She was frequently in altercations with the police and other people on the street, and it was not uncommon for her to curse staff in a tirade of verbal abuse upon approach. Using a harm reduction model with motivational interviewing and non-judgmental support, staff was successful in gaining her trust. The team compassionately supported her through many ups and downs, including periods of frequent relapse when she was forced to leave local motels and had recurrent police contact. Over time, she slowly started to control her drinking and drug use, taking ownership for her behavior and becoming more considerate and respectful. A Shelter Plus Care housing voucher was obtained and an apartment was found for her. The client has resided in her apartment for two months and has taken pride and demonstrated ownership in her new home by decorating and planting flowers in her front walkway. She has developed positive relationships with her neighbors and continues to develop increased independence.

IV. PROGRAMS FOR MULTIPLE POPULATIONS

26) Los Angeles County Housing Resource Center, (LACHRC; formerly known as the Socialserve Housing Database)
Goal: Provide information on housing listings to public users, housing locators, and caseworkers.
Budget: $382,000 ($202,000 allocation from HPI funding and $180,000 from CDC).

Table D1: LACHRC Program Measures **June 1, 2007 – March 31, 2010**	**Cumulative**	**Year 1 6.1.07 - 6.30.08**
Number of landlords registered on the site	8,837 *746 new*	3,505
Average monthly number of units available for rental	4,921	1,324
Total housing unit/ apartment complex listings registered on site (includes units that have been leased) *(as of December 2008)*	15,643 *943 new*	5,171
Total number of housing searches conducted by users that returned listing results	4,706,884 *568,849 new*	1,590,825
Average number of calls made/received to the Socialserve.com toll-free call center per month	4,167	2,897
Number of collaborative efforts forged between County Departments, Cities, and other stakeholder agencies	90 *7 new*	33

Successes: Third quarter numbers reflect a steady increase in all areas. The average increase of new landlords per month is 250, bringing the total to just under 9,000 this quarter. In early March, the Housing Economic Recovery Ownership (HERO) State Program information was added to the website. The Homelessness Prevention and Rapid Re-Housing Program (HPRP) pre-screening tool and mapping features continue to function well and assist County departments implementing the HPRP program.

Challenges: The priority of the stimulus programs continues to pose time pressures to the project administration. With the stimulus/recovery programs at the forefront of the work, the challenge is to blend the original website concept with the demand of the stimulus/recovery fund programs.

Action Plan: During the next quarter, the focus is to strengthen the original concept of the LACHRC. One addition will be the development of in-depth information pages that will expand information on housing resources for agencies and caseworkers. The outreach activities for the HERO, Neighborhood Stabilization Program (NSP) and HPRP programs will continue with general marketing and training, to improve overall awareness of the programs to agencies and the public alike.

Client Success Story: When realtors call to check on the availability of a listed property for the HERO and HERO State fund programs, they will often say that they were looking at the LACHRC website and that is how they learned about the property. The HERO and HERO State programs are on schedule to meet their narrow time-frame goals and the LACHRC has helped with that effort by providing property listings and mapping tools.

27) Los Angeles Homeless Services Authority (LAHSA) Contracted Programs

Goal: Emergency shelter and transitional housing are provided to families and individuals.
Budget: $1,735,000 (One-Time Funding)
Seven programs are currently in progress: two emergency shelters, three transitional housing, and two permanent supportive housing programs.

Table D.2: LAHSA Participants and Services

(unduplicated clients)	FY 2007-08	FY 2008-09	FY 2009-10 March 2010	Total
Homeless Families	483	275	209	967
Homeless Individuals	3,162	890	1,181	5,233
Chronic Homeless	2,206	358	354	2,918
Female	1,938	493	603	3,034
Male	3,931	1,003	1,242	6,176
Hispanic*	1,385	647	508	2,540
African American	2,838	636	778	4,252
White	2,004	1,097	992	4,093
Asian/Pacific Islander	151	83	82	316
Native American	168	110	24	302
Other	1,598	99	100	1,797
Adult	6,064	1,550	1,793	9,407
Child	1,029	444	356	1,829
Transition Age Youth *(not included as individuals)*	-	91	33	124
Emergency housing	5,869	1,462	1,504	8,835
Transitional housing	-	156	111	267
Permanent supportive housing	-	-	162	162

**LAHSA uses the federal definition of Hispanic origin (which for the Feds includes all Spanish speaking nations in the Americas and Spain). There are two options: Hispanic or Non-Hispanic.*
***The U. S. Department of Housing and Urban Development (HUD) defines an adult as a person 18 years of age or older. LAHSA uses the HUD definition of adult in its data collection process.*

28) PATH Achieve Glendale
Budget: $200,000 (Board Approved)
Successes: Access Center clients continued to experience success through their determination, hard work and assistance from staff. Community Street Outreach Case Managers completed another challenging, yet successful Winter Shelter season. From January to March 2010, the outreach team served 99 new clients (64 adults and 35 children). Of those, 89 received intakes and 26 were placed in shelter or housing. Community Street Outreach was responsible for spearheading the efforts to count homeless individuals on the streets of Glendale during the Homeless Count on January 20, 2010. Team members transported volunteers to known locations where homeless individuals and families could be counted through the use of a questionnaire gathering confidential demographic information. Volunteers and staff provided an essential segment of the necessary information used for determining funding and services for the Glendale area homeless population. Case managers were instrumental in assisting the outreach team in serving Winter Shelter clients and placing them in shelters by March 31st. Additionally, they served ongoing clients and 242 new clients. On March 18th, the case managers hosted the third annual Shelter Plus Care tenant breakfast. Sixteen clients attended the most successful breakfast thus far. Two Glendale Community Development and Housing officials attended to present information about ongoing requirements for program participants and answer their questions. The local Fresh Air Ambassador presented information on the Fresh Air Ordinance regulating smoking areas throughout the City. The last presenter from the California Department of Rehabilitation informed tenants about services available to disabled workers seeking training, vocational counseling and employment placement.

Challenges: All case managers have been working intensively with chronically homeless clients. Activities to assist newly housed clients have included furnishing apartments with donations, assisting with

obtaining money orders to pay rent and utilities, moving personal belongings out of storage, and helping clients access health care and deal with interpersonal problems. Following the early closure of Glendale's Winter Shelter Program at the armory, the outreach team was challenged to help chronically homeless disabled clients battle loneliness and disorientation to continue shelter in North Hills 20 miles away from areas familiar to them. They traveled to North Hills to perform case management duties at least daily, check in with clients, and provide food, referrals and transportation.

Table D.3: PATH Achieve Glendale
FY 2009-10, through March 31, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	574	Housing (emergency), average stay 60 days	415
Chronic Homeless	150	Housing (transitional)	66
Homeless Families	*316	Housing (permanent)	298
(Individuals)	948	Moving assistance	40
Female	715	Case management	427
Male	705	Education	11
Transgender	1	Job training	112
		Job placement	6
Hispanic	505	CalWORKs	2
African American	587	General Relief and Food Stamps	27
White	503	Medi-Cal/Medicare	2
Asian/Pacific Islander	31	SSI/SSDI	23
Native American	27	Health care	77
Other	9	Life skills	99
		Mental health care	93
Case management (level 3)			
Number of cases per case manager	76	Social/community event	20
		Substance abuse treatment (outpatient)	121
15 and below	411	Substance abuse treatment (residential)	1
16-24	178	Transportation	139
25-49	761		
50+	308		

Number enrolled in reporting period	242
Number who received an assessment	242
Number who exit prior to program completion	130
Number with three or more visits who have an increase in household income within one year	41
Number with at least three times who fulfill a savings plan by saving at least $250 per adult	16
Number who report no source of income at entry who reported a source of income at exit	24

**Through December 2009, a total of 796 individual family members was served; the number of families was calculated by dividing by three (estimated average family size).*
***FY 2008-09 transitional and permanent housing placement was estimated based on the ratio of transitional to permanent housing placements indicated in HMIS reports. The total number of placements (61 residents) was verified by an Emergency Housing Program report.*

Action Plan: The Access Center will be working on improving access to mental health services through increasing mental health groups and individual counseling hours available in house. Additionally, the Access Center will continue to analyze services to chronically homeless clients and develop further policy to guide practice across departments. The Center will also work toward improving relationships by establishing a referral exchange network and holding the first meeting among the Access Center's referral partners. Finally, throughout the next period, the Center will strategically endeavor to increase permanent subsidized housing resources clients may access through systematically identifying resources, advocating for new housing and equipping clients with necessary information and tools to secure housing.

Client Success Story: Client P, a single mother, came to PATH Achieve Glendale newly clean and sober, but without a job and without her children. After just five weeks in the Emergency Housing Program, the client had obtained a new job serving meals at a retirement home for $7.25 an hour and moved to the Transitional Housing Program, which provides low rent, case management, support and encouragement. She successfully completed the program in less than two years. Today her children live with her in a lovely two-bedroom apartment that she is able to pay for without assistance because she now earns $18 an hour as an executive secretary.

29) Pre-Development Revolving Loan Fund (RLF)

Goal: Affordable housing developers will receive loans directly from the Los Angeles County Housing Innovation Fund, LLC (LACHIF) to build much needed affordable housing in Los Angeles County.

Budget: $20 million (One-Time Funding)

Table D.4: Pre-development Revolving Loan Fund FY 2009-10, through March 31, 2010	**FY**
Number of applications received that are eligible for the RLF.	6
Number of projects with a complete environmental review within 90 days	1
Number of projects with environmental clearance	1
Average amount of time from receipt of application to loan approval	-
Dollar ($) amount of loans distributed by LLC	$3,700,000
Average length of time from loan close to loan maturity date	12 months
Average length of time from anticipated construction start to end date	-
Number of loans approved	1
Number categorized as predevelopment	-
Number categorized as land acquisition	1
Number of loans by Supervisorial District	
Supervisorial District 1	-
Supervisorial District 2	-
Supervisorial District 3	-
Supervisorial District 4	-
Supervisorial District 5	1
Number of special needs households to be served by each loan	0
Number of low-income households to be served by each loan	46
Number of proposed total and affordable housing units	46
Number of housing units to be developed at 60% or below AMI	46
Number of housing units to be developed at 35% or below AMI	-
Number of reports collected on time from LLC	3
Number/percent of lost loans (live to date)	-

Successes: During this reporting period, the Los Angeles County Housing Innovation Fund (LACHIF) closed one loan for $3.7 million. Additionally, Citibank also provided $20 million in Class A capital.

Challenges: The current lending environment has been a challenge for many affordable housing developers. Developers need to be able to access funds to pay off LACHIF loans.

Action Plan: LACHIF lenders and CDC staff continue to market the fund.

Client Success Story: The Hudson Oaks loan was made by Century Housing to Abode Communities. Hudson Oaks is located in the City of Pasadena and will provide 45 units of affordable senior housing.

30) Project Homeless Connect

Goal: Provide individuals and families with connections to health and human services and public benefits to prevent and reduce homelessness.

Budget: $45,000 (One-Time Funding)

Project Homeless Connect (PHC) is designed to bring government, community-based, and faith-based service providers together, as well as other sectors of the local community, to provide hospitality, information, and connections to health and human services and public benefits to homeless individuals and families. PHC provides a unique opportunity for homeless individuals and families to access services in a supportive, community-based, "one-stop shop" setting. The Los Angeles County, Chief Executive Office (CEO) participates as the lead organizer for local PHC Day events, which normally take place during the first week of December; however, recent need and popularity of PHC Day has resulted in events on an ongoing, year-round basis. In December 2009, 2,065 participants were connected to services through PHC. On February 24, 2010, the West Los Angeles Armory and the Culver City Armory held two PHC events that linked 147 individuals to housing, housing assistance, and a variety of supportive services. Thus, a total of 2,212 households have been connected to services since December 2009.

Successes: Table D.3 shows the total number of PHC participants who were linked to emergency, transitional, and permanent housing by fiscal year.

Challenges: With the current economic condition and the fact that families and individuals are losing their homes due to property foreclosures, future Project Homeless Connect events will need to continue to target the at-risk population.

Table D.5: Project Homeless Connect

Fiscal Year	Emergency Housing	Transitional Housing	Permanent Housing
FY 2006-07	59	-	70
FY 2007-08	117	19	-
FY 2008-09	235	78	25
FY 2009-10 (through March)	300	150	88
Total	711	247	183

V. CITY AND COMMUNITY PROGRAM (CCP) - ($32 million for Capital and Service Projects)

Capital Projects

Successes: During the third quarter, the CDC executed the contract with Cloudbreak Compton, LLC, for the Compton Vets Services Center. Construction is scheduled to begin in May, and is projected to be completed by January 2011. The CDC is in constant contact with all of the Capital Developers regarding the projects. The CDC has set up internal tracking systems to monitor project progress. The timeline for execution is being determined based on the need of each grantee. It is customary for grants to be executed near the start of construction. Loan agreements are being finalized for three capital projects.

Challenges: The progress of many projects has been delayed by the State budget freeze, and one project (Century Villages at Cabrillo) is still awaiting State funding. One project has been delayed due to the expiration of permits after contract was executed. Another project was stalled due to the withdrawal of the construction lender.

Action Plan: Continuing from the previous quarter: the CDC is determining with each developer, whether or not to enter into the grant agreements soon or if it is best to wait until near the beginning of construction to avoid the necessity of several amendments. The CDC staff will provide technical assistance and conduct site visits to projects that are not under the oversight of any other public agency.
Cumulative Expenditures to Date: $1,157,451 *(corrected from previous report to include only capital projects)*

Service Projects

Successes: To date, the CDC has executed 15 service contracts that are in full implementation. Four additional service contracts will be executed upon completion of the capital component of these projects. Programmatic and financial monitoring of projects continued in January through March, with six engagements completed through March and another nine scheduled in the next couple of months. Staff have visited all agencies and will start the second visits to agencies during next quarter. The results so far reveal that the programs are being implemented as proposed and costs are properly supported. Only minor deficiencies in internal control and administrative procedures have been noted.

Overall, a total of 28% of the funds associated with executed service contracts have been expended to date. The CDC has assisted a number of agencies in the submittal of payment requests and required documentation to support expenditures. Projects that had a slow start needed time to hire staff for key positions and to coordinate with subcontractors to ensure they meet all CDC requirements. Additionally, four service projects will not start until their capital project component is completed. At this point, it appears that most of the capital projects are moving forward and construction is anticipated to begin in 2010.

Challenges: The City of Pomona's Community Engagement and Regional Capacity Building project has experienced delays in getting started. Their sub-recipient, San Gabriel Valley Consortium, has yet to receive a non-profit determination from the Internal Revenue Service and as a result, has been unable to hire staff to implement the program. Thus, one of the partners in the Consortium, Service Center for Independent Living (SCIL), will serve as the fiscal administrator until the Consortium obtains its non-profit status and is able to operate as a separate legal entity. CDC staff conducted an assessment of SCIL's capacity to function as the fiscal administrator, and determined that they have adequate fiscal systems in place. As requested by the CEO, a portion of this contract has been allocated to another homeless organization. The CDC has returned $160,000 of these funds to the CEO. The City has submitted a formal amendment request and revised scope of services and budget, which the CDC has reviewed and approved. Delivery of services and payment reimbursements is expected to begin next quarter. The CDC will continue to closely monitor the progress of this project and work with the City of Pomona and SCIL in the implementation of the program. CDC staff have scheduled a monitoring site visit for next quarter.

During this quarter, one of two HHPF program Analyst positions was vacant. This position was filled by a former CDC employee, who began working in April 2010.

Action Plan: The CDC will continue to implement the programmatic and financial monitoring of the projects. Staff have completed 15 monitoring visits as of this writing, and have currently scheduled nine more by June 30, 2010. They plan to visit all agencies on a quarterly basis and will adjust the priority of these visits based on the results of previous monitoring reviews.
Cumulative Expenditures to Date: $5,943,231

31. City and Community Program (CCP)

a. Catalyst Foundation for AIDS Awareness and Care –Supportive Services Antelope Valley
b. City of Pomona: Community Engagement and Regional Capacity Building
c. City of Pomona: Integrated Housing and Outreach Program
d. Community of Friends (ACOF) – Permanent Supportive Housing Program
e. Homes for Life Foundation – Vanowen Apartments
f. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in the Antelope Valley
g. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in Long Beach
h. Ocean Park Community Center (OPCC) HEARTH
i. Skid Row Housing Trust – Skid Row Collaborative (SRC2)
j. Southern California Alcohol and Drug Programs – Homeless Co-Occurring Disorders Program
k. Special Service for Groups (SSG)
l. Union Rescue Mission - Hope Gardens Family Center
m. Volunteers of America Los Angeles – Strengthening Families
n. Women's and Children's Crisis Shelter

31a) Catalyst Foundation for AIDS Awareness and Care - Supportive Services Antelope Valley
Budget: $1,800,000 (City and Community Program)

Table E.1: Catalyst Foundation
FY 2009-10, through March 31, 2010

	Cumulative		Cumulative
At-risk Individuals	1,294	Education	386
At-risk Families	225	Job training	1
Homeless Individuals	24	Job placement	2
Homeless Families	15	CalWORKs	1
Chronic Homeless Individuals	12	General Relief	51
		General Relief and Food Stamps	4
Female	814	Food Stamps	1
Male	929	Medi-Cal/Medicare	5
Transgender	5	Section 8	2
		Case management	161
Hispanic	562	Health care	854
African American	553	Life skills	400
White	506	Mental health care	225
Asian/Pacific Islander	16	Transportation	145
Native American	10	Food	412
Other	83	Pet food/vet care	133
		Social/community activity	32
15 and under	23	Substance abuse treatment (residential)	1
16-24	646	Substance abuse treatment (outpatient)	2
25-49	573	Moving assistance	3
50+	241	Eviction prevention	10
		Rental subsidy	24
		Housing (emergency); avg. stay 120 days	1
		Housing (permanent)	2
Longer-term outcomes (six or more months)			
Continuing to live in housing			394
Obtained employment			2
Maintained employment			2
Case management			134
Health care			137
Mental health care			33
Substance abuse treatment (outpatient)			3
No drug use			3

Level 1 case management services	**Quarter**
Average for each participant per month	2 hours
Total hours for all participants	67 hours
Number of cases per case manager	67 cases
Number of organizations/agencies that your program has a formal collaboration for this project	33
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$533,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	40%
Number of participants who have enrolled (entered) into program during the reporting period	426
Number of participants who left the program during this period	-
Total number currently enrolled in program	426
Number of clients who received an assessment (if applicable)	67
Cost per participant	$150
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	n/a

FY 2008-09 may include duplicated counts. For FY 2009-10 to date, a total of 295 individuals and 99 families were served; complete demographic information was provided for head-of-household.

Successes: Three families that were on the verge of homelessness enrolled in the Case Management program and requested rental assistance. They had been living in unsafe and unaffordable housing. The three families obtained move-in assistance during this quarter, and they will be able to keep sustainable, affordable, and permanent housing. In addition to obtaining move-in assistance, they were able to access supportive services to enhance the stability of their housing situations, such as the food program. Staff will continue to accept new client registration packages and enroll new clients into the Case Management Program while following up with existing clients. The Catalyst Foundation continues to provide services to disenfranchised communities that are at high risk for homelessness. Services provided allow clients to maintain independent living arrangements and become self-sufficient. Clients mention that a major burden is relieved by the supportive services provided which allow them to focus on other aspects of their lives that require more attention.

The Catalyst Foundation continues to provide a continuum of services under one roof. Services are designed to meet each participant's unique, basic, and practical needs while addressing the root cause of childhood abuse and trauma. When providing services to participants, staff helps them identify high-risk behaviors and choices they are making that are putting them in difficult situations. At point of entry, participants continue to complete an ACE (Adverse Childhood Experience) questionnaire that provides information about the impact of childhood abuse and trauma on their lives. Outreach efforts have been extremely successful in targeting those who are homeless, at risk of homelessness, and the medically uninsured. In addition, the Outreach Department has been instrumental in promoting services and bringing in potential participants to obtain services. Such services include: primary medical care, mental health services, and case management to secure permanent housing, rental assistance, move-in, and utility assistance. The Supportive Services Department continues to provide food, transportation, legal assistance, support groups, and pet food. In addition, personal inner-growth classes such as: Yoga, Meditation, Martial Arts, Art, and Creating a Healing Society classes allow participants to help address unresolved trauma issues and incorporate healing modalities. The program has experienced a tremendous growth in the number of people wanting to access food, case management, and housing. Rental assistance and eviction prevention programs are very well solicited. During this quarter, three families obtained housing assistance and eviction prevention. Food services have been provided to over 300 participants this year. In addition, 50 people attended a wellness fair on March 30th. As a result, more participants have attended Yoga, Meditation, Therapy, and support groups. Furthermore, a therapy support group is being implemented to address substance use of our participants. Having the therapy support group on site will allow staff to better track the substance abuse outcome numbers.

Challenges: During this quarter The Catalyst Foundation Case Manager position became vacant. The Case Manager funded under this program was promoted to a Director position in the Prevention Department and continues to work within the organization. The new Director is receiving training on the data system. As a result, there has been some delay in data entry.

Action Plan: As a result the Supportive Services Coordinator II promotion to Case Manager, the Director of Supportive Services began to recruit to fill the vacant position. The position was advertised to existing employees, and a great candidate was identified. The Catalyst Foundation continues to improve current tracking systems to support data tracking management needs. The data management team continues to discuss and come up with solutions to simplify and improve the reporting process.

Client Success Story: Emergency housing was provided to a family of eight. They were in the process of moving into permanent affordable housing, when they were illegally asked to vacate their home. We immediately linked them to a housing rights center that provided assistance by educating and advocating for the family. In the meantime, the program placed the family in a hotel for one week, and they were finally able to move into safe, affordable housing. In addition, we assisted the family with a move-in assistance grant that allowed them to pay for their first month's rent and security deposit.

31b) City of Pomona: Community Engagement and Regional Capacity Building (CERC)
Budget: $1,079,276 (City and Community Program)

Table E.2: City of Pomona: Community Engagement and Regional Capacity Building
FY 2009-10, through March 31, 2010

	FY
Number of groups included in Consortium	41
Number of community meetings that the CEM and Consortium members attended	-
Number of speaking engagements (by CEM and Consortium)	-
Number of key leaders engaged with Consortium meetings	-
Number of cities actively involved in Consortium meeting	-
Number of strategies developed to eliminate barriers to service and housing delivery	-
Number of legislative, zoning changes, etc.	-
Number of cities actively engaged in strategic planning and/or community activity	9
Number of cities that designate a point person on staff to work on implementing recommendations	8
Number of organizations/agencies that your program has a formal collaboration for this project	11
Number of times collaborative partners met each month	1
Total amount($) of HPI funding leveraged for project	-
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	-

Successes: A request has been made to the CONSORTIUM to develop the first Y!MBY campaign to support a development effort for one of the local nonprofits. Nine cities are actively engaged in strategic planning and committee activity. Eight cities have a designated point person to work with the CONSORTIUM. The elected Board of Directors is in place. The Board and Ad hoc Executive Committee have developed the program design to launch the Y!MBY campaign, Resource Access System, and formalize the organization.

Challenges: The postponement of program implementation, as the CONSORTIUM worked to support new regional efforts, has resulted in a need for renewed momentum toward goals and differentiation of organizational mission. The CONSORTIUM will draw upon its long standing grassroots relationships and depth of experience working in the San Gabriel Valley to energize and define the organization. As progress is made in the Y!MBY Campaign and the Resource Access, the unique character and clear asset that the organization is, will become clear to community.

Action Plan: Within two months, the staff will be hired and the Community Engagement Manager will begin community outreach. Within three months, the Resource Desk will be operational. Within four months, the Web design agency will be identified and creation of the Regional Directory will have started.

31c) City of Pomona: Integrated Housing and Outreach Program (IHOP)
Budget: $913,975 (City and Community Program)

Successes: A major success for the IHOP Program is providing detox services for clients. It is extremely difficult for a client to be able to enter detox without the help of an agency. The waiting lists are extremely long, and clients have to call every single morning to see if it is their turn to enter. As most clients cannot afford the entrance fee, IHOP allows clients to enter detox immediately and not have to pay any fee. Once clients finish detox, they either enter residential treatment at American Recovery Center or another facility.

The Faith Based Committee established the First Faith Based Committee on February 17, 2010. The Pomona Continuum of Care Coalition (PCOCC) identified a gap within the continuum of care. Agencies are forced to turn down needed donations for lack of storage space. The PCOCC is working to create a collaborative Donation Storage Center. The Pomona Continuum of Care Coalition service data: January thru March 2010 served 1,505 homeless persons and 946 chronically homeless. For the grant year-to-date, 9,099 homeless persons were served and 6,700 chronically homeless.

Challenges: IHOP has been struggling to serve chronically homeless clients due to lack of income. They may have some sort of income (General Relief, Social Security), but it is not enough for permanent housing. Although options for shared living are available at a price they can afford, most chronically homeless clients do not want to live with anyone else, so they opt to continue to be homeless. The Faith Based Committee is needed as ambassadors to guide churches wishing to bring services to homeless persons in Pomona and to bring additional churches into the committee. The group must form a cohesive approach to work as a group in order to collaborate and search for options and resources to end homelessness; find the gaps within the Coalition of Care, and to work in unison without duplicating efforts. The group must raise funds for the inauguration. The PCOCC is tasked with the project of bringing a Donation Storage Center to the community so that members are not forced to turn down needed donations due to the lack of storage space.

Action Plan: Recently, the IHOP Program coordinator has linked with the Service Center for Independent Living (SCIL). SCIL has relationships with landlords that rent rooms at affordable prices, so this can be another option for chronically homeless who do not want shared transitional housing. If they choose, they can enter this shared housing, but have their own bedroom. In addition, SCIL has many disabled homeless clients who can afford housing, but just need assistance moving in, so this partnership will help IHOP to assist many more clients. The Faith Based Committee will form a Mission statement, establish guidelines, assign a chairperson, and work toward an Inauguration for June for the Committee and Chair with the Mayor of Pomona. The PCOCC will gain approval from the City of Pomona for an identified building in which to locate the Donation Storage Center.

Client Success Story: The very first client that went through the IHOP Program has now been receiving services for one year. This client was chronically homeless, entered detox at American Recovery Center, entered the Transitional Living Center, was approved for Social Security, moved out, and now owns his own mobile home. The client continues to do well at his job, where he is a dental hygienist, he attends Alcoholics Anonymous (AA) meetings, and he has reconnected with his children.

Table E.3: City of Pomona: Integrated Housing and Outreach Program
FY 2009-10, through March 31, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	21	Rental subsidy	27
Chronic Homeless	12	Moving assistance	2
Homeless Families (individuals)	30 93	Job training	5
Transition age youth	3	Job placement	7
Female	68	CalWORKs	1
Male	61	General Relief (and Food Stamps)	1
		General Relief	1
		Case management	69

Hispanic	38	Health care	4
African American	77	Life skills	11
White	11	Mental health care	20
Asian/Pacific Islander	2	Social/community event	3
Other	1	Substance abuse treatment (outpatient)	5
		Substance abuse treatment (residential)	5
15 and below	35	Transportation	10
16-24	28	Food	12
25-49	39		
50+	27	Case management (level 3)	
		Average hours for each participant	3
Eviction prevention	35	Total hours for all cases	185
Housing (emergency), average 44 day stay	28	Average caseload per case manager	8
Housing (transitional)	39		
Housing (permanent)	27		

Number ineligible (due to income/rent to income ratio/incomplete application/or other reason)	27
Number who remain in Transitional Living Center (TLC) for at least six months	5
Number who are compliant with a housing plan	5
Number who met their debt management and/or savings plan	5
Average change in income for participants (annually)	-
Number of agencies that use a uniform consent form	-
Number of meetings held by the Faith-based Committee	2
Number of organizations regularly participating on Committee	15
Number of agencies that received a current local Service Directory	27
Number of website hits for online directory	-
Number of agencies active	24
Number of service delivery recommendations implemented by the Committee and PCOC	-
Number of new collaborative relationships with landlords/owners/providers	-
Longer-term Outcomes (at six months)	
Continuing to live in housing	16
Obtained/Maintained employment	9
Enrolled in education program/school	1
Received high school diploma/GED	1
Case management	17
Health care	2
Mental health care	6
Substance abuse treatment (outpatient)	1
Reunited with family	2
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	18
Number of times collaborative partners met each month	3
Total amount($) of HPI funding leveraged for project	$10,400
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	28%
Number of participants who have enrolled (entered) into program during the reporting period	30
Number of participants who left the program during this period	1
Total number currently enrolled in program	34
Number of clients who received an assessment (if applicable)	30
Cost per participant	$801
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	1

31d) A Community of Friends (ACOF) - Permanent Supportive Housing Program
Budget: $1,800,000 (City and Community Program)

Table E.4: ACOF
FY 2009-10, through March 31, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	209	Education	88
Chronic Homeless	41	Job training, referrals	34
Homeless Families	125	Job placement	24
Female	341	CalWORKs	81
Male	299	General Relief w/Food Stamps	52
Transgender	1	General Relief only	5
		Food Stamps	4
Hispanic	148	Medi-Cal/Medicare	268
African American	366	Shelter Plus Care	209
White	112	SSI/SSDI	263
Asian/Pacific Islander	7		
Native American	-	Alternative court	3
Other	8	Case management	375
More than one race/ethnicity may be selected		Life skills	305
		Mental health	274
15 and below	186	Health care	206
16-24	73	Social/community activity	274
25-49	244	Substance abuse treatment (outpatient)	96
50+	138	Substance abuse (residential)	6
		Transportation	196
Moving assistance	13	Residential management support	212
Eviction prevention	61		
Rental subsidy	375	Case management (level 2)	
Housing (permanent)	375	Average hours per case:	7 hours
		Total number of hours:	7,164 hours
		Caseload:	17 cases

Longer-term Outcomes (at six or more months)	
Continuing to live in permanent housing	312
Receiving rental subsidy	312
Obtained employment	13
Maintained employment	19
Enrolled in educational program, school	43
Received high school diploma/equivalent	2
Case management	309
Health care	170
Good or improved physical health	160
Mental health care	225
Good or improved mental health	187
Recuperative care	2
Substance abuse treatment (outpatient)	61
Substance abuse treatment (residential)	5
No drug use	0
Reunited with family	5

Successes: A Community of Friends (ACOF) is pleased to report that the HPI funding has led to the continued successful collaboration with the Housing Works Mobile Integrated Service Team (MIST team). Collaboration with the MIST team continues to provide for intensive case management services for at risk tenants and tenants with specific needs. HPI funding also provides much needed on-going supportive services and case management at sites in need of such services. HPI funding allows for additional supportive services through property management support systems and provides for needed property maintenance. The ACOF residential service coordinators, with the assistance of the MIST team, helped 289 individuals and families who were formerly homeless maintain housing stability for 12 months or more. Furthermore, 186 have maintained their housing for 18 months or more.

The MIST team and residential service coordinators have met regularly to ensure a continued overlay of needed services for “at risk” tenants, played an integral role in preventing evictions for those tenants in jeopardy of losing housing, and residential service coordinators have been able to ensure that the majority of tenants remain permanently housed in a safe and healthy environment.

Housing Retention (of 375 participants ever served)		
All Current Tenants	339	90%
6 months or more	312	83%
12 months or more	289	77%
18 months or more	186	50%

Challenges: In previous quarters, there have been numerous challenges associated with aggregating the data reported by ACOF with the cumulative totals maintained by HPI. After careful review of the reported data and in-depth conversations with HPI staff, it appears that the issues surrounding the reporting tool and data aggregation have been resolved

Some tenants at ACOF’s Permanent Supportive Housing sites experience challenges such as managing their medication, budgeting funds, housekeeping, and maintaining sobriety.

Action Plan: ACOF has conducted a services department training to clarify the reporting process and introduced new tracking tools and monitoring procedures that will ensure the correct capture of data. The tracking tools were developed specifically to help simplify the aggregation of data from multiple properties at ACOF and continue to ensure error free data is submitted to HPI. Again, it is hoped that the training, tracking tools, and monitoring procedures at ACOF combined with the baseline data established last quarter with HPI staff will resolve the ongoing challenge with the reporting tool and data aggregation.

Residential service coordinators will continue to work with the MIST team to focus on those individuals most at risk of losing their housing. In addition, residential service coordinators will work with property managers on "best practices" to increase support in those instances when residential service coordinators are offsite. Also, all residential service coordinators regularly participate in department trainings as a means of strengthening staff skills and service capabilities.

Client Success Story: Tenant L has been a tenant with ACOF for more than 10 years. When he first moved in, he was able to reconnect with the community and things in life that were meaningful to him, such as his love for music and radio program production. After many years of a successful tenancy, Tenant L began disconnecting from his community and his mental health began to deteriorate. Symptoms of depression began to consume him and he ceased taking his medication. His once friendly behavior towards his neighbors and onsite staff became combative and unapproachable. His behaviors soon became detrimental to maintaining his housing and he was on the verge of eviction.

Tenant L was referred to MIST services in August of 2008. While working collaboratively with MIST, onsite supportive services staff, and property management, Tenant L slowly began to realize how his behavior was negatively affecting his relationships and his housing. An action plan was developed and the first step was to address his mental health needs. With support, Tenant L was able to restart his medication routine which helped stabilize his moods and behavior. Once stabilized, his relationships with other tenants and his support network were repaired and restored. In the process of addressing his immediate needs related to maintaining housing, it was determined that Tenant L would benefit from requesting a different, larger, unit that would allow him to continue addressing his needs and accomplishing his life goals.

As of present, Tenant L has improved immensely. Tenant L has connected with both the community within the building and the senior community in the area in which he currently resides. In addition, he conducts a radio show on the weekends and frequently assists other seniors at the local Senior Center. Tenant L has reaped the benefits of working collaboratively with the MIST team, onsite supportive services, and property management.

	Quarter
Number of organizations that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	35
Total amount ($) of HPI funding leveraged for project	$1,775,550
Percent of HPI funding leveraged for project	33%
Number of participants who have enrolled into program during the reporting period	8
Number of participants who left the program during this period	9
Total number currently enrolled in program	339
Number of clients who received an assessment (if applicable)	9
Cost per participant	$2,762
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	9
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	10
Program Specific Question:	
Number of participants who received benefits (as a result of the program)	375

31e) Homes for Life Foundation – Vanowen Apartments
Budget: $738,310 (City and Community Program)

Table E.5: Homes for Life Foundation (HFL) – Vanowen Apartments
FY 2009-10, through March 31, 2010

(unduplicated clients) *	Cumulative		Cumulative
Homeless Individuals	13	Housing (permanent)	25
Chronic Homeless Individuals	2	Rental subsidy	25
At-risk Individuals	10		
		Case management	25
Female	10	Life skills	25
Male	15	Mental health care	25
		Substance abuse treatment (outpatient)	5
Hispanic	2		
African American	6	Medi-Cal/Medicare	25
White	13	SSI/SSDI	25
Asian/Pacific Islander	3	Social/community event	25
Other	1		
25-49	13		
50+	12		
Number of participants who have completed at least two life skills courses			1
Number of participants who completed at least two personal goals set forth in their ISP			18
Longer-term Outcomes (at six months)			
Continuing to live in housing			23
Receiving rental subsidy			23
Case management			23
Health care			23
Good or improved physical health			23
Mental health care			23
Good or improved mental health			23
Case management (level 2)			
Average for each participant per month			3 hours
Total hours for all participants			375 hours
Number of cases per case manager			12 cases
Number of organizations/agencies that your program has a formal collaboration for this project			2
Number of times collaborative partners met each month			1
Total amount ($) of HPI funding leveraged for project			$10,100
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)			46%

Number of participants who have enrolled (entered) into program during the reporting period	-
Number of participants who left the program during this period	-
Total number currently enrolled in program	24
Number of clients who received an assessment (if applicable)	25
Cost per participant	$1,340
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Note: An unduplicated number of clients is provided in this report. Previous reports showed a duplicate number.

Successes: A total of 21 out of 25 residents (84%) have maintained housing for 12 months. Two more will achieve that goal during April. All 25 residents have received and maintained all benefits for which they are eligible. A total of 75% of residents (18 out of 24) were able to successfully meet at least two personal goals as established on their personalized service plans. One client has not been in the program long enough for outcomes to be generated.

Challenges: HFL Vanowen staff worked closely with clients experiencing challenges with managing their mental health. Many of these residents have not lived independently, so staff assisted them with developing the skills necessary to maintain their apartments and care for themselves in a new environment. These challenges have all been met with successful interventions such that clients have been able to maintain their housing for their full first year of occupancy.

Action Plan: Staff will continue to work with clients toward meeting personal and program goals.

Client Success Story: One resident is a 57-year-old male who has lived at Homes for Life Vanowen for a year. He is thankful everyday for the fact that he was given the opportunity to move from his transitional living apartment that he shared with four other people. His issues began when he started to struggle with depression. His depression was so crippling that he tried to take his own life. He feels that when he was struggling, he found it very difficult to ask for help. He now feels like he has his own space and that has helped him to focus on himself and his overall well-being. He no longer sees asking for help as a bad thing. The feeling of support has aided his ongoing quest of working with his depression. He really enjoys the other residents and how friendly and kind they are. He takes advantage of the resources offered to him by both the HFL Vanowen program as well as the Victory Wellness center next to his apartment. He rarely misses a group that is offered and always is supportive of other residents when they share their issues. He has met his barriers head on and, with the support of others, tries everyday to maintain his positive outlook on life. In closing, this resident stated that he feels inspired and happy now that he has a place to call his home.

31f) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
Budget: $900,000 (City and Community Program)

Table E.6: Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
FY 2009-10, through March 31, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	92	Shelter Plus Care	6
Chronic Homeless Individuals	105	General Relief and Food Stamps/GR	3
		Medi-Cal/Medicare	5
Female	90	General Relief	2
Male	107	Food Stamps	3
		SSI/SSDI	9
Hispanic	25	Case management	197
African American	90	Social/community activity	5
White	77	Substance abuse treatment (residential)	2
Asian/Pacific Islander	2	Mental health	197
Other	3	Health care	2
More than one race/ethnicity may be selected		Like skills	6
		Transportation	197
16-24	16		
25-49	138	Education	4
50+	43	Job training	31
		Job placement	2
Moving assistance	16		
Housing (emergency)	2	Case management (level 2)	
Housing (transitional)	13	Average hours per case:	80
Housing (permanent)	33	Total number of hours:	240
		Caseload:	49

Program Specific Measures	**Quarter**
Number of TAY who have obtained a technical school or college degree while in program	-
Number of participants who have a primary care physician	1
Number of participants who have a dentist	-
Number of participants with good or improved recovery status (substance abuse)	-
Longer-term Outcomes (at six or more months)	
Continuing to live in housing	7
Case management	105
Good or improved physical health	2
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	-
Number of times collaborative partners met each month	-
Total amount ($) of HPI funding leveraged for project	$78,658
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	80%
Number of participants who have enrolled (entered) into program during the reporting period	44
Number of participants who left the program during this period	9
Total number currently enrolled in program	189
Number of clients who received an assessment (if applicable)	44
Cost per participant	$698

Note: New baseline was provided in third quarter of FY 2009-10 as a result of updated files/revisions.

Successes: The program successfully assisted members with move-in costs which allow members to be placed in permanent stable housing.

Challenges: It has been challenging to have members follow through with continuous care and case management.

Action Plan: The program continues to research and locate more affordable housing as well as build more community relationships. Staff will continue to outreach and connect with distant members in the community.

Client Success Story: Staff had been trying to engage a member for months. She has been difficult to engage due to being extremely mentally ill. This member struggles with paranoia, audio and visual hallucinations to the point where she cannot have a lucid conversation with others. Due to a great team effort and available funding sources, the program finally was able to make a connection with her, get her

hospitalized and stabilized in January. Once she became stabilized with medication, staff coordinated with the hospital to have her discharged into a stable transitional house in February. She was immediately connected with the program's psychiatrist for continued treatment, and staff is working with her on a daily basis to support her in the transitional living program as well as to obtain income. The member is currently doing well and appears to be much healthier.

31g) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Long Beach
Budget: $1,340,047 (City and Community Program)

Table E.7: Self Sufficiency Project for Homeless Adults and TAY Long Beach
FY 2009-10, through March 31, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	55	Case management	67
Chronic Homeless Individuals	27	Job placement	17
Transition Age Youth	8	Benefits assistance/advocacy	3
		Bus tickets	*336
Female	15		*number of tickets*
Male	75	Transportation	45
		Housing (emergency)	18
Hispanic	18	Average stay in emergency housing (day)	4
African American	25	Housing (permanent)	12
White	40	Rental subsidy	2
Native American	1		
Other	5	Job training	9
Demographics do not match total population.		Job placement	7
16-24	9	Mental health	27
25-49	42	Health care	2
50+	39	General Relief and Food Stamps	2
		Medi-Cal/Medicare	6
Case management (level 3)		SSI/SSDI	9
Average hours per case:	14		
Total number of hours:	428		
Caseload:	10		

Program Specific Measures	**Quarter**
Number of TAY who have obtained a technical school or college degree while in program	-
Number of participants who have a primary care physician	9
Number of participants who have a dentist	-
Number of participants with good or improved recovery status (substance abuse)	-
Longer-term Outcomes (at six months)	
Continuing to live in housing	6
Obtained employment	19
Maintained employment	14
Enrolled in education program, school	1
Case management	60
Health care	3
Good or improved physical health	1
Mental health	21
Good or improved mental health	17
Substance abuse treatment (outpatient)	1
Reunited with family	7
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	-
Total amount ($) of HPI funding leveraged for project	$90,540
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	69%
Number of participants who have enrolled (entered) into program during the reporting period	31
Number of participants who left the program during this period	2
Total number currently enrolled in program	56
Number of clients who received an assessment (if applicable)	13
Cost per participant	$1,128

Successes: This has been a very successful quarter. Since receiving the grant money, 26 people have been placed in permanent housing and staff work on new referrals every week. Approximately two-thirds (59%) of the members served have reached one or more of their case management goals. Staff have been able to add additional resources to this grant with the assistance of a U.S. Department of Housing and Urban Development (HUD) grant. This addition will provide ongoing rent payments to 12 youth ages 18-25. Once they have received a security deposit and first month's rent from CDC, the HUD grant will help further sustain them while coming up with a plan for self-sufficiency. In the month of February, the program housed its first two youth, and with this combination of services, they are adjusting very well. In addition, several SSI applications are pending approval. Also, an adjustment in the program's budget was granted to include some eviction prevention funds, and this has already assisted in preventing two of the CDC grant members from being evicted.

Challenges: First, the program has experienced a slower pace with job opportunities arising. Staff assumes that a big part of this is due to the economy. Second, while the program has a great SSI approval success rate, the program is looking at other model programs that decrease time for SSI approval.

Action Plan: The action plan to meet these challenges includes: 1) Spending an increased amount of effort in the field, networking and meeting potential employers for our Day Labor Members; and 2) Continuing to attend trainings regarding SSI/Benefits advocacy, and create a connection with the BEST team in Los Angeles to learn their strategies and means of success with quick approval times.

Client Success Story: Client B, age 24, was identified as one of the most vulnerable homeless youth in the downtown Long Beach area during the recent *Homeless Connections Initiative* in Long Beach (modeled after Los Angeles' *Project 50*). The client comes from a family history that includes mental health issues, substance abuse, homelessness, and poverty. When staff met him during homeless outreach, he was being allowed to stay at a local church over night because he had no place to live, and his mother was in a similar situation so could not offer him any support. Although Client B has mental health issues and a history of trauma, staff gained his trust and started talking to him about what "he wanted" in life, offering him meals, and getting to know him. Within a few months, staff helped him locate an apartment and assisted him with the funds. The program paid his rent for the next six months with the additional HUD grant. The program helped him explore local colleges and job opportunities, and his chances at self sufficiency and happiness are looking very good. This would not have been possible without the support of this grant.

31h) Ocean Park Community Center (OPCC) HEARTH

Budget: $1,200,000 (City and Community Program)

Table E.8: OPCC HEARTH
FY 2009-10, through March 31, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	691	Education	-
Chronic Homeless	328	Job training, referrals	2
Transition Age Youth	62	Job placement	1
		Food Stamps	1
Female	355	Shelter Plus Care	9
Male	726	Section 8	20
		SSI/SSDI	1
		Medi-Cal/Medicare	2
Hispanic	70	Case management	183
African American	297	Life skills	31
White	657	Mental health	15
Asian/Pacific Islander	20	Health care	1,081
Native American	6	Social/community activity	44
Other	31	Recuperative care	126
		Substance abuse (residential)	1
		Substance abuse (outpatient)	9
15 and below	13	Transportation	66
16-24	104	California identification	7
25-49	508	Veterans	2
50+	456	Legal	3
		Locker	9
Moving assistance	10	Mail	5
Housing (emergency)	58	Clothing/hygiene	7
Housing (permanent)	26	Case management (level 3)	
Housing (transitional)	22	Average hours per case:	204
(Average 22 days in temporary housing)		Total number of hours:	612
		Caseload:	39
Longer-term Outcomes (six or more months)			
Continuing to live in permanent housing			15
Receiving rental subsidy			7
Case management			29
Health care			22
Good or improved physical health			16
Mental health care			0
Good or improved mental health			0
No drug use			1

Successes:

Since the program's inception in September, 2008, OPCC Project HEARTH has provided the following:

- A *medical home* consisting of primary outpatient health care to 1,081 unduplicated homeless adults in the Santa Monica area provided by Venice Family Clinic physicians located at OPCC's Access Center;
- 126 unduplicated individuals received respite care at OPCC Samoshel following an acute medical condition, including surgery or illness;
- 69 (55%) of individuals exiting the respite bed program have secured temporary or permanent housing; and
- 183 individuals who received primary health care became engaged in case management.

Housing retention rates:

- 23 individuals were permanently housed and 15 maintained housing for 6 months (65% retention rate);
- Eight individuals maintained permanent housing for 12 months (57% retention rate); and
- An individual maintained permanent housing for 18 months (100% retention rate).

Challenges:

- Lack of low income housing options for medically vulnerable individuals;
- Lack of the necessary income to access affordable housing options;
- Few housing and income resources exist for undocumented clients; and
- Clients' inability to address untreated mental illness on parity with other medical issues.

	FY
Number of organizations that your program has a formal collaboration for this project	4
Number of times collaborative partners met each month	2
Total amount ($) of HPI funding leveraged for project	$2,239
Percent of HPI funding leveraged for project	54%
Number of participants who have enrolled into program during the reporting period	210
Number of participants who left the program during this period	-
Total number currently enrolled in program	613
Number of clients who received an assessment (if applicable)	29
Cost per participant	$432
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	n/a
Program Specific Question:	
Number of participants who received benefits (as a result of the program)	18

- Lack of locally-based senior housing

Action Plan:

- Continue to improve the process of discharging homeless patients from the local hospitals into the respite program and OPCC Access Center (through scheduled OPCC Project HEARTH orientations to hospital personnel);
- Refer housed clients for in-home supportive services; and
- Develop housing application workshops for clients to apply for Section 8 wait lists and other available housing resources.

Client Success Story: Client A, 58 years of age, was a hotel manager for the Four Seasons Hotel for most of his adult life. His dream was to own his own restaurant. He left his stable job and became the owner of a fine dining establishment. Unfortunately, his business only lasted six years. In 2001, the client lost much of his investments in the stock market downturn. This brought on much stress and depression. Client A worked odd jobs until his health began to decline.

The client had been living with his partner of 20 years. In 2008, she passed away and he was unable to afford the apartment they had been living in. He was unable to find a place to stay and began living in a garage. It was during his first year of homelessness when his health drastically declined. The client underwent major surgery, leaving his right leg and left eye amputated.

In March 2009, Client A came to OPCC's ACCESS Center for medical services. His leg and his eye were at risk of infection. He needed medication and a place to recuperate but he did not have access to his benefits due to complications in receiving Medi-Cal. OPCC Project HEARTH was able to utilize motel vouchers to provide him with local emergency housing. With staff support, his Medi-Cal was reinstated and he was able to move into a skilled nursing facility. For the next year, HEARTH staff continued to provide intensive case management. Client A has lived in several nursing homes and hospitals. HEARTH's on-going case management was crucial when he was in need of crisis intervention. There were times when he would refuse life saving surgery and when he was at risk of being evicted from his nursing home. HEARTH staff coordinated efforts with hospital social workers, doctors, and discharge planners to keep him continuously housed. He now lives in his own subsidized two-bedroom apartment in Gardena. Project HEARTH continues to provide intensive case management, home visits and linkage to a local grocery program. Staff have also connected him with In-Home- Supportive-Services and, with the help of WCIL (Westside Center for Independent Living), his apartment will be made handicap accessible. He has enrolled in college and began physical therapy for the use of his new prosthetic leg. Now stably housed, the client is actively pursuing his goal to walk again.

31i) Skid Row Housing Trust – Skid Row Collaborative (SRC2)
Budget: $1,800,000 (City and Community Program)

Table E.9: Skid Row Housing Trust
FY 2009-10, through March 31, 2010

(unduplicated count)	Cumulative		Cumulative
Chronic Homeless Individuals	117	Case management	110
Female	33	Mental health	92
Male	84	Health care	84
		Life skills	64
Hispanic	8	Social/community activity	47
African American	95	Substance abuse treatment (outpatient)	78
Asian/Pacific Islander	21	Substance abuse treatment (residential)	10
Other	1	Transportation	19
More than one race/ethnicity may be selected		Benefits advocacy	39
		General Relief and Food Stamps	12
16-24	2	Medi-Cal/Medicare	18
25-49	55	SSI/SSDI	18
50+	60	Legal	3
		Food	16
Rental subsidy	117	Supervised volunteer work	24
Housing (permanent)	117		
Shelter Plus Care	117	Case management (level 3)	
Education	7	Average hours per case:	6
Job training	41	Total number of hours:	622
Job placement	7	Caseload:	25
Longer-term Outcomes			
Continuing to live in housing			89
Receiving rental subsidy			89
Enrolled in education program/school			40
Obtained employment			2
Maintained employment			42
Case management			86
Health care			66
Good or improved physical health			58
Mental health			73
Good or improved mental health			62
Substance abuse treatment (outpatient)			65
Substance abuse treatment (residential)			3
No drug use			30
Reunited with family			63
			Quarter
Number of organizations/agencies that your program has a formal collaboration for this project			2
Number of times collaborative partners met each month			4
Total amount ($) of HPI funding leveraged for project			$150,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)			72%
Number of participants who have enrolled (entered) into program during the reporting period			6
Number of participants who left the program during this period			5
Total number currently enrolled in program			98
Number of clients who received an assessment (if applicable)			45
Cost per participant			$3,000
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter			3
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter			2

Successes: The overarching goals of this program are to help residents maintain their housing and increase their ability to live independently. Because it is the program's belief that a healthy community encourages and supports positive life choices, staff together with residents have been working over the past year to develop a program where residents have a variety of psycho-educational classes to choose from. Each month, the Tenant Publications Committee produces a Class Catalog and Calendar. This 22-page booklet includes a letter from the Program Manager, a list of the integrated services team members and the services they provide, an updated list of monthly events, and short descriptions of the 27 classes/groups available to residents each week. These groups range from art journaling and cooking classes to seeking safety and an all fellowship group. In addition, the committee publishes a monthly

newsletter called “Changing Times.” The newsletter features short articles by resident reporters, works of fiction and poetry by residents, an article by staff focusing on one of the classes in the catalog, and a resident-selected recipe of the month. Resident interest in contributing to the newsletter has continued to increase since its inception. The catalog has inspired residents to suggest additional groups, classes, and activities. The residents’ excitement and interest in shaping their program is an important sign of their engagement in and feeling of ownership over the community that all are building together. As the program ends its first year in operation, the team feels confident that they can continue to build on this initial success.

Challenges: No significant challenge was reported this quarter.

Action Plan: N/A

Client Success Story: Client H moved into the Abbey Apartments in the spring of 2009. She is 59 years old. Before moving to the Abbey, she spent eight years living in a large Los Angeles park that is known for being very dangerous – especially for women. Her addiction to crack made it difficult for her to easily obtain or maintain employment. She lived on handouts from strangers. Her hygiene was very poor and during her interview for housing, she was tearful and appeared very depressed. She walked with a cane and stated that she suffered from a great deal of pain due to a badly injured knee. She had been severely beaten while she was homeless and had no support system.

It was no surprise to us that after moving into the Abbey, her room quickly became exceptionally dirty and she had problems paying her rent on time. The adjustment was very difficult for her and over time it became apparent that she may always need a high level of support. Staff worked with her to obtain a payee ensuring that her rent would be paid on time. Staff also helped her obtain an IHSS worker who could assist her with her household chores. When she first moved in, the staff was concerned about her ability to live independently and maintain her housing even with additional support. Twelve months later, she is doing very well. Client H wears clean clothes now, styles her hair, and wears fingernail polish. Her room is clean. She has had surgery on her knee and walks better than she has in several years. She has made contact with several of her family members. She smiles as she walks through the lobby secure in the knowledge that she has a safe place to call her own.

31j) Southern California Alcohol and Drug Programs (SCADP), Inc. - Homeless Co-Occurring Disorders Program
Budget: $1,679,472 (City and Community Program)

Table E.10: SCADP
FY 2009-10, through March 31, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	126	Housing (transitional)	3
Homeless Families (individuals)	25 60		
Transition Age Youth	29	Mental health care	208
At-risk Individuals	32	Substance abuse treatment (residential)	75
Chronic Homeless Individuals	28	General Relief	4
Female	88	At six months:	
Male	154	Continuing to receive mental health care	10
Transgender	1	Good or improved mental health	9
Hispanic	113		
African American	41	Average length of stay for residents (days)	92
White	78	Residents discharged due to graduation	18
Native American	7	Discharge status for residents of transfer	2
Asian/Pacific Islander	6	Discharge status for residents of walk-out	8
15 and under	38	Discharge status for residents, violated rules	8
16-24	32		
25-49	154		
50+	26		

Number of participants who left the program during this period	36
Total number currently enrolled in program	65
Number of clients who received an assessment (if applicable)	41
Cost per participant	$1,000

Successes: This project is an expansion/continuation of a prior federal grant to integrate mental health services into residential substance abuse treatment. The HPI project funds pay specifically for mental health services only. Prior to this, the program offered many services onsite (substance abuse education, relapse prevention, parenting, GED classes, vocational prep, life skills, HIV/STD education, family planning education, and domestic violence education). Two areas which were often reasons for relapse where trauma (histories of) and untreated/undiagnosed psychiatric disorders. With this project's funds these problem areas are included in onsite treatment. Two areas of positive results have been noted: 1) clients are staying in treatment longer, and 2) completion rates have risen. The project is providing part to all of the mental health services to four residential substance abuse treatment programs and also is now providing continuing psychiatric services to treatment program graduates who have moved into sober living/supportive housing services and permanent housing services through a 'parent' agency. All treatment programs are three to six months, so the ability to continue with some graduates allows capture of longer-term data. Some of those graduating from this project's services are double graduates, in that they have completed residential treatment, moved to sober living and are now leaving the agency to live independently in the community.
Challenges: One area which needs constant work is de-stigmatizing the need for mental health services and improving clients' knowledge of mental health conditions and psychiatric disorders. Although decreased, a continued fear of "being crazy" has been observed by incoming residents.

Action Plan: Addressing the stigma and fear of mental health and psychiatry on a continual basis is important. Having mental health services, especially psychiatry onsite allows for earlier intervention. Staff tries to schedule all new admits to meet with the addiction psychiatrist. Increasing the number who meet with the doctor has helped decrease the stigma (it is no longer assumed that the psychiatrist only sees "special people" and seeing the doctor does not automatically mean medication). This is important because it has become evident that almost all of the residents benefit from mental health services. Most do need psychiatric services. Their psychiatric conditions are usually undiagnosed. About 50 to 80% (depending on the program) can and do benefit from psychiatric medication.

Client Success Story: Here are stories of three participants currently receiving services who are at the 12 month mark. All are living lives much improved compared to 12 months ago. One is settled in the community, because of their ages the other two are still finding their way. The one who is settled is 53 years old. In the past six months she has received a Section 8 voucher and her SSDI benefits. She is now established in her own permanent place. Shortly after moving in, she had a heart attack. She was hospitalized for some time. Unlike before, she contacted her family and support network. When she was released, she moved back home and began attending heart health classes at the hospital. She commented had this happened before she went into treatment, she probably would have left the hospital and not told anyone and hit the pipe again. She is proud that she was able to endure this exceedingly stressful event in her life without resorting to drugs (she could not remember when this happened before).

Another client is 21 years old. She continues in a supervised sober living. She has now completed three semesters of college. She has commented that she likes the structure and support provided by her housemates. When she transfers to a four-year school, she is thinking about residing in a dorm so she would not be feel isolated, and her peers would notice if she begins isolating and withdrawing socially.

The third client is a young man in his late twenties who isolated himself from his family and friends. Upon graduation from the program, he moved in with his girlfriend. This proved to be quite stressful, so he contacted family and now lives with one of his siblings. He is working at a professional office and finds he enjoys his work. He has decided he likes helping people and is considering doing some pro bono service. He commented he can think clearly now and is no longer wrapped up in his own mind - he is surprised he is actually enjoying living much of the time.

31k) Special Service for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program
Budget: $1,800,000 (City and Community Program)

Table E.11: SSG
FY 2009-10, through March 31, 2010

(unduplicated clients)	FY		FY
Homeless Individuals	74	Moving assistance	14
Homeless Families	106	Rental subsidy	27
(individuals)	325		
Transition Age Youth	15	Housing (emergency)	75
At-risk Families	51	Housing (transitional), average stay 11 days	60
(individuals)	145	Job training/resources	46
		Job placement	17
Female	337	Education	1
Male	222	Case management	244
Hispanic	35	Life skills	230
African American	502	Mental health care	10
White	20	Social/community activity	2
Other	2	Other	41
15 and under	235	CalWORKs	8
16-24	63	General Relief	3
25-49	200	Section 8	7
50+	52	SSI	14
Case management (level 3)		Substance abuse treatment (outpatient)	3
Average hours per participant per month	127	Transportation	54
Total hours for reporting period	382	Food	12
Number of cases per case manager	17	Eviction prevention	35
		Food Stamps only	6
		Medi-Cal/Medicare	15
		Housing (permanent)	53

Longer-term outcomes (at six or more months)	
Continuing to live in housing	82
Receiving rental subsidy	2
Obtained employment	19
Maintained employment	47
Enrolled in education program/school	1
Case management	3
Substance abuse treatment (outpatient)	1
Substance abuse treatment (residential)	-
No drug use	3
Reunited with family	1
Number of organizations/agencies that your program has a formal collaboration for this project	5
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$2,635,657
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	68%
Number of participants who have enrolled (entered) into program during the reporting period	66
Number of participants who left the program during this period	51
Total number currently enrolled in program	83
Number of clients who received an assessment (if applicable)	66
Cost per participant	$2,975
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	20
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Successes: January-March 2010 marked the third successful operating quarter of the stated contract. SSG is on track to meeting program outcomes. According to recent audit findings, the program outcomes were reviewed and in good standing. The program is on track to meeting the annual goal of serving 300 homeless individuals and families. The contract is fiscally on track. It is projected that the program will end the fiscal year with a balanced budget. Progress has been made in developing a data collection tool to appropriately and efficiently capture outcomes reporting data. Last quarter, SSG and its sub-recipient partners began addressing the need to create new bed slots to temporarily house intact families and

fathers with children. Through these discussions, SSG's sub-recipient was supported in opening a new facility with the capacity to serve this population. Through this contract, SSG is now able to meet its need in appropriately housing any family type, and this marks the greatest success of the quarter.

Challenges: For various reasons, the agency had to terminate its sub-recipient contract with Kheper Life Enrichment Institute. This leaves the program with about $30,000 to reallocate elsewhere.

Action Plan: SSG is exploring different options in determining the best way to reallocate the unused funds made available through Kheper's sub-contract termination. A revised budget and clear plan will be submitted to the program analyst for approval by the middle of the fourth quarter. The Project Director will continue to receive technical assistance through the CEO's office to develop a data and outcomes tracking system using the Access software. The data collection system is 75% complete.

Client Success Story: A single mother with five children came into the program at high-risk of becoming homeless. The client and her children were living in a substandard apartment that impacted the health and well-being of her and her children. The client was encouraged to relocate after an official determination deeming the apartment uninhabitable. Having nowhere to go and without the additional income needed to move into new housing, the client enrolled into the program in need of housing and supportive services. While enrolled, the client was able to access an array of resources offered to her. With the help of the program, the client was assisted with: securing suitable and permanent housing; accessing supportive services to help her manage her finances, health and well being; and navigating community resources.

31l) Union Rescue Mission (URM) – Hope Gardens Family Center

Budget: $1,853,510 for services and $646,489 for capital (City and Community Program)

Table E.12: Hope Gardens
FY 2009-10, through March 31, 2010

(unduplicated count)	Cumulative		Cumulative
Homeless Families	63	CalWORKs	155
(individuals)	197	Food Stamps	158
		Medi-Cal/Medicare	144
Female	115	Section 8	5
Male	58	SSI/SSDI	6
		Veterans	3
Hispanic	49		
African American	81	Case management	93
White	25	Life skills	59
Asian/Pacific Islander	4	Mental health	114
Other	14	Health care	53
		Social/community activity	201
15 and below	100	Substance abuse treatment (outpatient)	33
16-24	16	Transportation	203
25-49	47		
50+	6	Case management (level 1)	
		Average hours per case:	17
Moving assistance	29	Total number of hours:	53
Housing (emergency)	12	Caseload:	15
Housing (transitional), *average 579 days*	152		
Housing (permanent)	24	Education	106
		Job training, referrals	43
		Job placement	27
Longer-term outcomes (6 or more months)			
Continuing to live in housing			28
Receiving rental subsidy			13
Obtained employment			1
Maintained employment			1
Enrolled in educational program/school			1

Successes: During the 2010 third quarter, the Hope Gardens Family Center (HGFC) transitioned five families (16 individuals) of which four families (11 individuals) were relocated into permanent housing and one family (5 individuals) transitioned into a more appropriate transitional housing program due to non-compliance. During the course of this fiscal year, Hope Gardens has transitioned 14 of the 42 families that have received services at our transitional living facility. Thirty-one families remain in the program as of the date of this report. During this past quarter, the families transitioned into the following areas:

- Four families (11 individuals) were housed in permanent housing. The placement consisted of two families that were placed in shared housing and two families obtained Section 8 subsidized housing.
- One family (five individuals) was transitioned to a more appropriate transitional housing setting.
- To date a total of 51 out of 82 families served have transitioned from HGFC – 37 of those 51 families (72%) obtained permanent housing and 14 families transitioned to other temporary or emergency housing facilities.
- Families maintaining permanent housing are as follows:
  Six months or less eight families
  Nine months or less Four (4) families
  Twelve months or more seven families

Challenges: URM has begun the construction project for the Sycamore Building, which would give HGFC approximately 10 to 15 additional family units. This has been a very slow process working through funding, contracting and permitting issues. Meanwhile, eight families at the URM downtown facility await space at HGFC and would like to get out of the Skid Row area as soon as possible. Staff is also working out funding challenges to complete the Concord building, which would add approximately eight new units and needs significant rehabilitation. URM hopes to have that project completed by the end of 2010 if they can raise sufficient funds. As a result of the increase in the capacity to provide services, they anticipate an increased need for support staff as well. The greatest challenge for URM and HGFC right now is one of funding. When HGFC opened to families in 2007, this vital project added a $4 million increase in operational funding that needed to be raised. Shortly thereafter, the economy took a catastrophic turn for the worst and left URM with a huge deficit in funding to cover the operational needs of this large, yet critical program. The HHPF funding has been a real life-saver to HGFC and URM, yet it only covers one-fourth of the overall need. Obtaining affordable housing units remain a challenge for low-income residents. Income levels below the poverty line, averaging approximately $364 per month, only widen the gap for homeless families to qualify for housing. URM has seen the trend where homeless families are deemed ineligible for low-income housing because they do not have sufficient income to meet the minimum income standards at approximately $13,000 per year.

Many families face additional challenges in the area of housing affordability. For example, many families are being denied housing due to “bad credit.” These families were selected to secure Section 8 vouchers because the mothers were victims of domestic violence. One client disclosed during her application process that her credit was destroyed after she fled her batterer and she was denied a housing voucher that she had previously been qualified. Many federally funded programs have been unable to secure or provide new vouchers, which leaves many families who were promised vouchers feeling frustrated like they do not have options. Others are burdened with the enormous task of securing living wage employment with minimal job skills. Still others have been unsuccessful in finding affordable/subsidized housing to meet their individual family needs.

Number of organizations/agencies that your program has a formal collaboration for this project	2
Number of times collaborative partners met each month	4
Total amount ($) of HPI funding leveraged for project	$249,600
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	41%
Number of participants who have enrolled (entered) into program during the reporting period	8
Number of participants who left the program during this period	6
Total number currently enrolled in program	106
Number of clients who received an assessment (if applicable)	3
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Action Plan: HGFC continues to focus more efforts on the Employment/ Vocational Development Department to assist families in securing employment or increasing their job skills and educational levels in this demanding economic market. The Hope Gardens Design Center seeks every opportunity to form relationships with designers from the fashion industry to develop a career path. The team continues to work with potential employers to secure employment outside of Hope Gardens within six to nine months after apprenticeship training. The program will make every attempt to move forward on the construction project for the Sycamore Building, which would give HGFC approximately 10 to 15 additional family units. At a 77% housing placement success rate, HGFC program staff is managing to house families despite the economic downturn. Although the program still faces some challenges in locating sustainable housing and employment options, the team's persistence is benefiting HGFC women and children greatly. HGFC staff are addressing the challenges of each family individually and holistically as they continue to work with participants to identify barriers that have kept them from achieving (and exceeding) their goals.

Client Success Story: "I am a mother of four children with a history of domestic violence. During this experience I learned a great deal about myself. I knew nothing but abuse from early adolescence until today. I was victimized at home at the age of 17 and thought I found refuge with my boyfriend. I really did not escape the abuse and after our marriage the violence and abuse just continued to escalate. Unprotected at home, traumatized and abused was my norm, I knew no other way. At first I did not know that I was being victimized because I started to feel like I deserved the abuse. My entire life just began to unravel by the day.

We were homeless - my husband, three children and I was expecting our fourth child. We did however find safe refuge from the streets at URM after being evicted and living out of our car. Life began to turn around for my family at URM, then I lost my husband to another homeless women. He left me at the shelter in the middle of our crisis. I was very angry and simply tired; tired of trying to reach for perfection. Obtaining perfection would ensure our family stability, surely he would stay. If, I simply did not lose my job we could be in our home with our children. If I could – could do what – anything to make him stay. I became angrier because I had a consistent reminder of my loss. I was living in the place of my most recent hurt. It was not the physical facility but the emotional trauma that continued.

I masked the hurt and even our children were displaying anger. I did not think that my children were affected until we truly removed ourselves from the domestic violence (DV) cycle. We were encouraged to move to Hope Gardens where hope is eternal, but of course I resisted the programming. When I arrived at Hope Gardens, I was certainly in denial about being a victim of DV. I simply believed that a job and housing would cure all my past hurts. My husband began coming around again trying to derail me, telling me everything would get better, but it did not work. The staff was very diligent and moved to protect me from my norm and I am so glad they did. My case management plan was stricter and I began to engage in the recommended DV treatment which was the best decision of my life. I began to trust, feel and hope again. My children are part of the community and engaged in processing through the assistance of the clinical team and we are on our way to a life changing transformation.

Throughout my ordeal I found guidance, safety and refuge as the staff at Hope Gardens walked me through the process every step of the way. I was assisted as I navigated through the various obstacles as a caring staff kept me steady until I was able to stand on my own. I am currently in the housing search phase and looking forward to a place of our own."

31m) Volunteers of America - Los Angeles, Strengthening Families
Budget: $1,000,000 (City and Community Program)

Table E.13: VOALA
FY 2009-10, through March 31, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Families	71	Alternative court	12
(individuals)	314	Case management	348
At-risk Families	99	Life skills	227
(individuals)	492	Mental health	85
		Health care	44
Female	418	Social/community activity	185
Male	378	Substance abuse treatment (outpt.)	2
		Transportation	177
Hispanic	805	Food	140
Other	2	Medi-Cal/Medicare	103
		CalWORKs	51
15 and below	423	General Relief w/Food Stamps	21
16-24	100	General Relief only	2
25-49	258	Shelter Plus Care	1
50+	14	SSI/SSDI	16
		Food Stamps only	72
Eviction prevention	129	Section 8	49
Moving assistance	74	Legal	31
Housing (emergency; avg. stay 5 days)	17	Clothing	117
Housing (transitional)	6		
Housing (permanent)	12	Education	65
Rental subsidy	7	Job training, referrals	178
		Job placement	39

Average stay at emergency housing:	60 days
Number placed into transitional housing:	14 families
Case management (level 2)	
Average case management hours for each participant per month:	5 hours
Total case management hours for all participants during current reporting period:	338 hours
Number of cases per case manager:	23 cases
Longer-term Outcomes (at six or more months)	
Maintained permanent housing (through eviction prevention, linkages to jobs)	200
Receiving rental subsidy	15
Obtained employment	33
Maintained employment	36
Enrolled in educational program, school	30
Received High School Diploma/GED	5
Case management	217
Health care	81
Good or improved physical health	105
Mental health care	39
Good or improved mental health	115
Substance abuse treatment (outpatient)	2
No drug use	2
Reunited with family	4

Successes: During this quarter, Strengthening Families served over 80 families with finding housing, resources and employment. Additionally, the Strengthening Families program assisted five families with security deposits, which allowed them to move into permanent housing. Through the partnership and collaboration with community agencies, Strengthening Families directly assisted clients with obtaining furniture and other much need items for their new homes. After the families moved into their new homes, the Strengthening Families staff continued to work and provide support to the family to ensure that the family continues to meet their goals. The current focus of Strengthening Families continues to be assisting families with relocating to transitional housing with the final goal being that the family finds permanent housing and employment. The case managers also continue to provide the families with individualized support/ referrals to services and resources that will enable them to overcome the various challenges that they face in regards to finding permanent housing and employment. Through various

partnerships and collaborations with local community and governments agencies, such as Bienvenidos, Jovens Inc., Volunteers of East Los Angeles and many others, Strengthening Families is building a strong network of support and services that families are learning to use and benefiting.

	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	5
Number of times collaborative partners met each month	4
Total amount($) of HPI funding leveraged for project	$1,000,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	50%
Number of participants who have enrolled (entered) into program during the reporting period	38
Number of participants who left the program during this period	6
Total number currently enrolled in program	133
Number of clients who received an assessment (if applicable)	75
Cost per participant	-

Challenges: The Strengthening Families case managers continue to face many challenges when attempting to assist and advocate for their families. The biggest obstacle that continues to challenge the case managers is finding permanent housing at an affordable rate or low income housing. Since many of the families do not have stable incomes or have their own small business, they tend to not have proof of income and because of this many property managers are not willing to rent to the families. Additionally because many of the families do not have permanent residency, they are unable to qualify for low income housing or other housing programs, so immigration continues to be another challenge. In addition to the challenges of lack of permanent housing and immigration, the case managers are also being challenged with the lack of financial knowledge of families. Most families that come into the program do not have any savings or bank account which many believe to be unnecessary.

Action Plan: In collaboration with other community based agencies, Strengthening Families is working on setting up a collaborative of agencies that work with homeless families in the area of East Los Angeles, so that together a more effective delivery of services can be established. Additionally the collaborative will serve to connect those agencies that are providing services and support to the homeless population in East Los Angeles and thus provide better and more services to the families. Strengthening Families will continue working and seeking additional resources and services for the families in the areas of permanent housing and employment.

Client Success Story: A family of two adults and three children were living in a converted garage that was falling apart. Because of the converted garage's poor condition, a neighbor called social services to investigate. The City inspector came to the house, and because the garage was unsuitable for living and had been converted into a makeshift house without a permit, he informed the family that they would have to vacate the premise. Shortly after the visit by the city inspector, the landlord presented the family with a letter to vacate the premises by the end of the week. The stress of the family's living situation caused many arguments between mom and dad and eventually dad left mom and their three children. The case manager was able to assist mom with finding affordable permanent housing, and VOALA was able to provide mom and her three children with the security deposit for their new home. The case manager also assisted mom in enrolling in employment readiness classes and is now employed. Additionally, the case manager assisted mom with filing for full custody of her children, and she was granted child support.

31n) Women's and Children's Crisis Shelter
Budget: $300,000 (City and Community Program)

Table E.14: Women's and Children's Crisis Center (WCCS)
FY 2009-10, through March 31, 2010

(unduplicated clients)	Cumulative		Cumulative
Homeless Families	76	15 and below	168
At-Risk Individuals	564	16-24	115
		25-49	356
Female	636	50+	37
Male	103		
		Case management	24
		Housing (permanent)	1
Hispanic	461	Housing (emergency)	118
African American	101	Housing (transitional)	4
White	67	Average stay in days *(for quarter)*	16
Asian/Pacific Islander	11	Number to shared living w/friends or family	6
Native American	2	Life skills	23
Other	97	Mental health care	67
Families are made up of individuals.		Transportation	75
		Job training	1
		Job placement	1
		CalWORKs	10

Case management (level 1)	
Average case management hours for each participant per month:	2 hours
Total case management hours for all participants during current reporting period	28 hours
Number of cases per case manager:	3 cases

Program Specific Measures	**Quarter**
Number of hotline calls that are related to domestic violence issues.	135
Number of hotline calls that are related to homeless issues.	42
Of the calls related to domestic violence, the number of families/individuals at-risk of becoming homeless.	51
Number of individuals reunited with their families.	-

Number of families who have enrolled (entered) into program during the reporting period	11
Number of families who left the program during this period	9
Total number of families currently enrolled in program	3
Number of clients who received an assessment (if applicable)	9
Cost per participant	$616
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	2
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	6

Successes: Several emergency shelter clients exited into their own housing with financial stability, and 11 clients and their children exited with restraining orders in place. One transitional client completed the transitional program and obtained permanent housing.

Challenges: Five emergency shelter clients entered with undiagnosed mental health issues; each ended up exiting early because they were unable to sustain the environment of shelter living. This caused tremendous chaos with the other clients in the last three months.

Action Plan: The emergency shelter staff established twice-weekly case management meetings with the shelter therapists, rather than only once a week, in order to discern mental health issues with the clients more quickly.

Client Success Story: Client E and her four children entered long-term transitional shelter. The family continues to receive therapy to address their abuse issues. The client has a five-year permanent restraining order and continues to receive legal help.

VI. COUNCIL OF GOVERNMENTS (COGs)

32a) San Gabriel Valley Council of Governments
Budget: $200,000 (On-going Funding)

In April 2009, a study team consisting of the Corporation for Supportive Housing, Shelter Partnership, Inc., Urban Initiatives, and McDermott Consulting, presented the San Gabriel Valley Regional Homeless Services Strategy Final Report to the San Gabriel Valley Council of Governments (SGVCOG). The final report included a summary of priorities presented by sub-regional cluster group and the following key issues were identified.

- First Priority: Permanent Supportive Housing
- Second Priority: Short-Term Housing (Emergency Shelter & Transitional Housing)
- Third Priority: Access Center

Implementation Strategy and Recommendations
A summary of five-year housing and service targets was presented by cluster group. Overall for the region, three strategic objectives, related recommendations, and a timeline were presented.

Strategic Objective I: Develop Leadership, Political Will, and Community Support

- Recommendation 1: Create a Valley-wide Membership Based Organization for the Primary Purpose of Education, Advocacy, and Coordination
- Recommendation 2: Meet and Confer with Municipal Leaders, Community Groups, Business Leaders, Faith-based and Community Service Providers within the San Gabriel Valley

Strategic Objective II: Build Provider Capacity and Expand the Service Delivery System

- Recommendation 1: Engage Community and Faith-based Service Providers in Planning, Training and Overall Capacity Building
- Recommendation 2: Create More Housing Opportunities for Homeless Persons in the San Gabriel Valley
  - √ 588 units of permanent supportive housing over the next five years
  - √ 150 emergency shelter beds and 300 transitional housing beds for single individuals over the next five years
  - √ Scattered-site housing programs to serve 100 families annually
- Recommendation 3: Create an Access Center in Cluster Five (Claremont, Diamond Bar, Glendora, La Verne, Pomona, and San Dimas)
- Recommendation 4: Develop Valley-wide Referral and Information Sharing System

Strategic Objective III: Leverage and Maximize Utilization of Available Financial Resources

- Recommendation 1: Form a San Gabriel Valley Supportive Housing Pipeline Review Committee
- Recommendation 2: Commit Local Investments from Municipalities Across Multiple Jurisdictions within the San Gabriel Valley to Stimulate Housing Production
- Recommendation 3: Utilize New Funding Opportunities to Expand Short-term Housing and Rapid Re-housing Programs

32b) PATH Partners/Gateway Cities Homeless Strategy
Budget: $135,000 (On-going Funding)

PATH Partners presented the Gateway Cities Homeless Strategy to the Gateway Cities Council of Governments (GCCOG). The first three categories (LEAD, ENGAGE and COLLABORATE) provide recommended actions that will build the leadership and infrastructure required to plan, develop and successfully start up the proposed programs and services presented in the IMPLEMENTATION category of the strategy.

The LEAD phase includes identification of a current or new regional leadership entity as well as designating a “Homeless Liaison” for each city. The ENGAGE phase involves formation of a stakeholder regional homeless alliance, implementation of “connections” strategies to engage the community, and

development of a public education campaign. Third, the COLLABORATE category focuses on enhanced government-wide collaboration. Specific strategies include: leveraging $1.2 million of County HPI funds to secure matching dollars within the region, exploring opportunities to secure funding from the American Recovery and Reinvestment Act of 2009, and organizing and coordinating the GCCOG cities to apply for additional funding; and coordinating a region-wide, multi-sector homeless collaborative event that integrates services and resources across agencies and departments, including government departments, service providers, faith groups and the business community. One example of an effective event that has produced demonstrated results in several communities are "Homeless Connect Days." The County of Los Angeles currently sponsors events that bring together hundreds of volunteers to engage homeless people and connect them to needed services all on one day.

The IMPLEMENT phase consists of four categories of implementation actions that are proposed as part of the Gateway Cities Homeless Strategy, which are all very closely intertwined and form a mini-"homeless strategy" in a region that effectively assists homeless individuals and families to move from the streets into housing and long-term independence –

√ **Homeless Prevention Services**: The region will create a minimum of two new homeless prevention programs over the next 12 months to provide prevention services to the homeless. A target goal is to have a total of four programs formed (one in each of the four group areas of the GCCOG region), over the next 3-5 years to provide accessible prevention services to those in need. Each homeless prevention program will serve 500 unduplicated individuals annually, providing screening and assessments, prevention programs and housing assistance.

√ **First Responders Program**: Geographic-based street outreach team(s) would serve as "first responders" and coordinate with local law enforcement, service providers, hospitals, businesses and others. Teams would be comprised of staff and/or volunteers, and would be multiPATH Partners 2009 disciplinary, utilizing staff from existing mental health providers, substance abuse treatment providers, county agencies, and faith groups. The GCCOG region will create a minimum of two new outreach teams over the next 12 months to provide outreach services to the Gateway Cities. A target goal is to have a total of four teams operating (one in each of the four group areas of the GCCOG) over the next 3-5 years to provide more accessible outreach services. Each outreach team will engage 80 new unduplicated homeless individuals and assist them in connecting to services annually.

√ **Interim Housing**: Develop a strategy to "rapidly re-house" individuals into interim housing, with the end goal of long-term housing. This approach will be linked to street outreach teams and will focus on intensive housing and placement assistance upon entry into interim housing, and will include linkages to housing subsidies, rental assistance programs and other supportive services. Cities/communities would place special emphasis on connecting existing interim beds and programs to street outreach, homeless prevention services, permanent supportive housing and other supportive services. The region will create a minimum of two new interim housing programs (30-40 beds per program) over the next 12 months. A target goal is to have four new interim housing programs (one in each of the four group areas in the region) over the next 3-5 years to provide housing. Each new program will serve 100 unduplicated homeless individuals annually, providing them with housing, case management and assistance in connecting to long-term housing opportunities and supportive services.

√ **Permanent Supportive Housing (PSH)**: Create a multi-year plan to increase the stock of PSH units in the GCCOG region. A proposed goal for the region is to invest in the creation of 665 units of PSH over the next five years (2010 to 2014). The production goal of 665 new units will double the number of available supportive housing units. The goal is based on an assessment of the available funding resources the GCCOG will be able to realistically access to support the creation of new PSH units. The breakdown of the 665 unit production goal over five-years includes: one 40 unit development, 175 units of smaller PSH projects and set aside units, and 450 scattered-site leasing units. A plan will be developed for acquiring further rental vouchers and/or creating more subsidized housing in the region for homeless families and single adults who do not require supportive housing but do require affordable housing in order to end their homelessness as they transition out of interim housing.